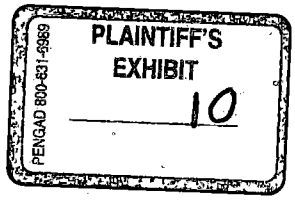
EXHIBIT 29



Georgia

UNIFORM APPLICATION
FY 2020/2021 Community Mental Health Services Block Grant Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 12/03/2020 3.29.41 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State DUNS Number

Number 965736635

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Georgia Department of Behavioral Health and Developmental Disabilities

Organizational Unit Division of Behavioral Health

Mailing Address 2 Peachtree Street, 24-290

City Atlanta

Zip Code 30303

II. Contact Person for the Grantee of the Block Grant

First Name Judy

Last Name Fitzgerald

Agency Name Department of Behavioral Health and Developmental Disabilities

Mailing Address 2 Peachtree Street 24-290

City Atlanta

Zip Code 30303

Telephone 404-463-7946

Fax 770-408-5480

Email Address judy.fitzgerald@dbhdd.ga.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 9/3/2019 9:21:47 PM

Revision Date 12/3/2020 3:28:59 PM

VI. Contact Person Responsible for Application Submission

First Name Jill

Last Name Mays

Telephone 404-657-5681

Fax

Email Address jill.mays@dbhdd.ga.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Judy Fitzgerald

Signature of CEO or Designee[1]: _____

Title: Commissioner Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

STATE OF GEORGIA
OFFICE OF THE GOVERNOR
ATLANTA 30334-0900

Brian P. Kemp
GOVERNOR

August 19, 2019

Ms. Odessa Crocker
Grants Management Officer
Office of Financial Resources,
Division of Grants Management
Substance Abuse and Mental
Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857

Re: The Community Mental Health Services Block Grant (MHBG) and
The Substance Abuse Prevention and Treatment Block Grant (SABG)

Dear Ms. Crocker:

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), specifically the Division of Behavioral Health, is currently identified as the Single State Authority for community mental health and substance use services. As the Governor of the State of Georgia, for the duration of my tenure, I delegate authority to the current Commissioner of DBHDD, or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG).

On behalf of the citizens of the State of Georgia, I thank you for the opportunity to continue our participation in this grant program.

Sincerely,

Brian P. Kemp

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

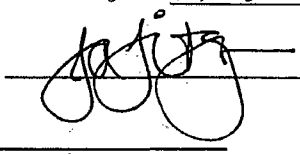
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Judy Fitzgerald

Signature of CEO or Designee[1]: 

Title: Commissioner

Date Signed: 08.29.2019

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Georgia Department of Behavioral Health
& Developmental Disabilities

Judy Fitzgerald, Commissioner

D·B·H·D·D Division of Behavioral Health

November 5, 2019

Tiffany Pham
Grants Management Officer
Division of Grants Management
Department of Health and Human Services
SAMHSA

Wendy Pang
Grants Management Officer
Division of Grants Management
Department of Health and Human Services
SAMHSA

Re: Marijuana Attestation for Georgia Mental Health Grants

- Block Grant for Community Mental Health Services (**Grant Number: 3B09SM010061-19S3**)
- Georgia AIME SOC Grant (**Grant Number: 6H79SM080153-02M001**)
- PATH Grant (**Grant Number: 6X06SM016058-19M001**)

Dear Grants Management Officer:

As per the Terms and Conditions stated in the revised NoAs, dated October 10, 2019, I certify that the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and all sub-recipients of the above stated grant programs will comply with the following NoA language:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

DBHDD remains committed to the goals of our SAMHSA grant programs and to providing easy access to high-quality care that leads to a life of recovery and independence for the people we serve.

Sincerely,

Judy Fitzgerald, Commissioner
Department of Behavioral Health and Developmental Disabilities

CC: Monica Johnson, Director, Division of Behavioral Health, DBHDD

Jill Mays, Director, Office of Federal Grant Programs & Cultural and Linguistic Competency, DBHDD
Letitia Robinson, State PATH Contact, Assistant Director, Office of Supported Housing, DBHDD
Dante McKay, Director, Office of Children, Young Adults, and Families, DBHDD
Matthew Clay, AIME Program Director, Office of CYF, DBHDD

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

N/A

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

STATE OVERVIEW

THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

Created by the Governor and General Assembly in 2009, the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and its network of community providers offer treatment and support services to help people with behavioral health challenges achieve recovery by focusing on their strengths. Through uniquely tailored supports and services, the department also helps people with intellectual and developmental disabilities attain independence and lead meaningful and fulfilling lives. DBHDD's vision is "Easy access to high-quality care that leads to a life of recovery and independence for the people we serve". The mission is "To lead an accountable and effective continuum of care to support people with behavioral health challenges, and intellectual and developmental disabilities in a dynamic health care environment.
As a Cabinet-level department, DBHDD is the state agency responsible for administration, coordination, planning, regulation and monitoring of all components of the state public behavioral health and intellectual and developmental disability systems. DBHDD operates state hospitals and provides for community-based services across the state through contracted providers. As Georgia's public safety net, the department's primary responsibility is to serve people who are uninsured. Individuals on Medicaid and others with few resources or options are also served.

DBHDD Commissioner

Judy Fitzgerald was appointed Commissioner of DBHDD in December 2016, and reports directly to the Governor of the State of Georgia. Commissioner Fitzgerald, who is a social worker with a career-long focus on behavioral health and public health delivery systems, has been with DBHDD since 2012, previously serving in the roles of Chief of Staff and Deputy Commissioner.

DBHDD Board of Directors

The Board of Georgia DBHDD establishes the general policy to be followed by the department. The nine-member Board of Directors is appointed by the Governor and confirmed by the Senate. Each member of the board is appointed for a term of three years following initial appointments of staggered terms as provided by the state statute.

Behavioral Health Coordinating Council

DBHDD is also advised by a Behavioral Health Coordinating Council (BHCC), which is administratively attached to DBHDD. The Council members include the Commissioners of the Departments of Corrections, Human Services, Juvenile Justice, Labor, Public Health, Community Affairs (Housing) and Community Health (Medicaid authority); the State Superintendent of Education; the Chairperson of the State Board of Pardons and Paroles; one

Senator, one Representative, one family member of a consumer, one parent representative and one adult consumer. The Council is led by an executive committee comprised of a chairperson, vice-chairperson, secretary and two other members. The Commissioner of Behavioral Health and Developmental Disabilities serves as the Chairperson of the Council.

The purpose and mission of the BHCC is to identify overlapping services regarding funding and policy issues in the behavioral health system. The BHCC is specifically tasked with developing solutions to the systemic barriers or problems to the delivery of behavioral health services by making recommendations that implement funding, policy changes, practice changes, and evaluation of specific goals designed to improve services delivery and outcome for individuals served by the various departments; focusing on specific goals designed to resolve issues for provision of behavioral health services that negatively impact individuals serviced by at least two departments; monitoring and evaluating the implementation of established goals; and establishing common outcome measures. The BHCC has regularly consulted with various stakeholders around the state to understand the realities, needs and resources of/for individuals living with behavioral health challenges. The BHCC since its inception has considered and discussed a range of issues including transportation, children and adolescents, sharing of health information, housing, funding, partnerships, and workforce development. In addition, there are two BHCC sub-committee's which serve at the discretion of the Executive Committee and BHCC; one on children and youth services, the Interagency Director's Team (IDT), and one that focuses on the transition of individuals with behavioral challenges from the criminal justice system back into the community, that is the Transition Re-entry Committee.

Commissioner's Executive Leadership Team

Guided by its vision and mission, the Department has reshaped its organizational structure to create a centrally-managed model that is aligned by function. DBHDD's vision is "Easy access to high-quality care that leads to a life of recovery and independence for the people we serve". The mission is "To lead an accountable and effective continuum of care to support people with behavioral health challenges, and intellectual and developmental disabilities in a dynamic health care environment." DBHDD is organized through the Commissioner's Executive Leadership team which consists of several Office and Division Directors. This includes the Commissioner, Deputy Commissioner/Chief Operating Officer, Assistant Commissioner/General Counsel, Director of the Division of Hospital Services/Chief Medical Officer and Directors of the Office of Public Affairs, Division of Developmental Disabilities, Office of Hospital Operations, Special Projects, Division of Behavioral Health, Division of Accountability and Compliance, Division of Performance Management and Quality Improvement, Office of Budget and Finance, Office of Human Resources and Learning, and Office of Information Technology.

Three of the Divisions mentioned above were created during the restructuring: Division of Accountability and Compliance, Division of Performance Management and Quality

Improvement and the Division of Behavioral Health, all pertinent to the successful operation of behavioral health services. The Division of Accountability and Compliance is responsible for the monitoring and testing of compliance with contractual, regulatory, and health and safety standards; and, conducts coordinated reviews including provider audits, incident investigations and follow-up reviews. The Division of Performance Management and Quality Improvement (PMQI) is responsible for utilizing data, trends, and system knowledge to systematically and consistently manage a network of providers and promote improvements in performance and quality of services. PMQI achieves this via several functions: Coordination and management of the administrative services organization; Utilization of research methods, program measurement and evaluation to analyze data; Development and implementation of an integrated quality framework, quality monitoring, and related initiatives; Consolidated office of provider network management; and, Coordination with Medicaid/DCH and other external partners to support health systems innovation. The third Division, Division of Behavioral Health, is described in the next section.

The Division of Behavioral Health

The **Division of Behavioral Health (DBH)** is overseen by Monica Johnson, MA, LPC, who reports directly to the Commissioner of DBHDD and is responsible for providing leadership for all behavioral health services for children and adolescents, emerging adults and adults. There are 9 offices within this Division: Adult Mental Health (OAMH); Children, Young Adults and Families (OCYF); Addictive Diseases (OAD); Behavioral Health Prevention (OBHP); Deaf Services (ODS); Recovery Transformation (ORT); Field Operations; Crisis Services; and Federal Grant Programs and Cultural and Linguistic Competency (OFGP/CLC). DBH is the authority for behavioral health programs, services and supports statewide. The primary areas of focus are policy and planning; program development; budget management and spending plan development, workforce development; and, collaboration with stakeholders. Some of the key responsibilities are:

- Guide statewide clinical best practices
- Develop service guidelines
- Identify and develop standards, policies and key performance indicators
- Identify and implement short and long-term programmatic improvement initiatives
- Develop strategic planning and implementation of services
- Serve as subject matter experts for external and internal stakeholders
- Provide technical assistance and training to ensure competency with the provider network

The Division's goal is to build a recovery-oriented, community-based system of care, with the capacity to provide timely access to high-quality behavioral health treatment and support services. Recovery accepts that severe and persistent mental illness, substance use, and co-occurring disorders are long-term conditions that a person will be managing for life. This model signifies a shift from crisis-driven services to a prevention-focused continuum of care that

provides sustained support, and is based on the strengths, wellness, and goals of the person in recovery. The division also supports policy development, service planning, program development, budget development, workforce development (training), and external collaboration with stakeholders across the system of care. The following information describes each of the Offices within DBH.

The **Office of Adult Mental Health (OAMH)** is led by the Director of OAMH. It is staffed with 19 staff: an Assistant Director responsible for traditional outpatient Core Services, , and Crisis Services; three staff responsible for mental health treatment/accountability courts, three staff responsible for oversight of Supported Employment including fidelity reviews and technical assistance; three staff responsible for oversight and fidelity monitoring for ACT and CST; one staff responsible for emergency preparedness and disaster planning; three staff responsible for community transitions; four staff responsible for supported housing, residential rehabilitation services, Homeless Outreach and crisis respite apartments; one staff responsible for intensive case management and case management, and, one staff responsible for administrative support. The adult mental health staff members provide programmatic and policy expertise and direction to many enterprise initiatives as well as other intergovernmental and interagency collaborations. They have developed memoranda of understanding and other types of partnerships with organizations including the Division of Aging Services within the Department of Human Services, the Department of Community Health, the Department of Community Affairs, the Department of Vocational Rehabilitation Services, and the Department of Public Health, Department of Community Supervision, Department of Corrections, and other governmental and non-governmental agencies.

Georgia statute assigns specific responsibility for developing programs for children and adolescents in need of mental health services to DBHDD. The **Office of Children, Young Adults, and Families (OCYF)** (formerly referred to as the Office of Child and Adolescent Mental Health) within the Division of Behavioral Health is primarily focused on child and adolescent mental health services. There is also a focus on transition age youth and young adults through age 26. In partnership with DBHDD's OAMH and OFGP/CLC, efforts have been put forth to ensure the design and delivery of a behavioral health system that is fully responsive to emerging adults with serious mental health conditions.

OCYF is supported by the Office Director, who is the primary point of contact on all child and adolescent mental health considerations. The office is organized into five practice areas: Clinical Services, Community Based Programs, Parent and Youth Peer Support, System of Care Expansion, and Workforce Development. Clinical Services includes electronic crisis system monitoring, crisis stabilization, mobile crisis response services, and psychiatric residential treatment facilities. Community Based Services includes community innovation grants, high-fidelity wraparound, mental health resiliency support clubhouses, school-based mental health, state-funded system of care grants, and supported education/supported employment. Parent and

Youth Peer Support includes certification training, continued education, and technical assistance. System of Care Expansion involves our latest SAMHSA grant to further expand system of care in Georgia. Workforce Development includes capacity building through ongoing local, regional, and statewide training, including our annual System of Care Academy. DBH's **Office of Addictive Diseases (OAD)** provides leadership for adult and adolescent substance use disorder treatment services. The responsibilities include: program oversight, grants management; ensuring compliance with federal and state funding requirements; maintaining collaborative relationships with advocacy groups and other stakeholders; providing data and information at the regional and local levels to impact policy decisions; statewide technical assistance to providers and the six DBHDD Field Offices; developing and maintaining collaboration among private and public sector providers and stakeholders; providing training and information on best practices for substance use disorder treatment; coordinating collaborative efforts in increasing best practices models; assisting community and faith-based groups in developing capacity and training; overseeing HIV Early Intervention Services among substance users and their families and significant others; overseeing men's residential treatment services throughout Georgia and the Women's Treatment and Recovery Services program; and carrying out gambling prevention activities.

The Office of Addictive Diseases and the Office of Adult Mental Health coordinate treatment and training issues regarding service delivery to those with co-occurring substance use and mental health disorders. By contract and policy, all state providers of services must be co-occurring capable. Georgia has spent several years providing statewide training to ensure competency in assessing and treating both mental illness and substance use disorders. In addition, both offices share the same service definitions in the state Provider Manual and work in harmony to ensure that adults, children and adolescents have an integrated system of care.

The **Office of Behavioral Health Prevention (OBHP)** is an office focused on Substance Abuse Prevention, Suicide Prevention and MH Promotion. In February of 2015, OBHP re-organized to reflect some of these common linkages and shared risk and protective factors with Substance Abuse and Suicide Prevention, and Mental Health Promotion. OBHP utilizes a public health approach (population based) and the Strategic Prevention Framework Model (Assessment, Capacity, Planning, Implementation and Evaluation). The OBHP staff currently consist of 19 positions: the Director, an Administrative Assistant, a Strategic Prevention Framework (SPF) System Coordinator and a Data Specialist, a Regional Prevention Specialists Supervisor and four Regional Prevention Specialists, a SYNAR/Special Projects Administrator, a PFS (GenRx) Coordinator, SPF Rx Coordinator, a State Targeted Response (STR) Opioid Coordinator, a STR Opioid Specialist, a Suicide Prevention Coordinator, a GLS Youth Suicide Prevention Director, a Suicide Prevention Specialist, a Leave Specialist, and a SAMHSA Prevention Fellow. Currently there are 14 projects under the Substance Abuse Prevention segment of OBHP and 4 projects under the Suicide Prevention segment of OBHP. The newly added Mental Health Promotion

segment of OBHP is currently under Strategic Planning for incorporation throughout OBHP's work.

The **Office of Deaf Services (ODS)** American Sign Language (ASL) fluent staff include a Director, Clinical Director, Community Services Coordinator (currently vacant), Interpreter Coordinator, and a Staff Interpreter who are committed to providing deaf, hard of hearing, or deaf-blind individuals easy access to behavioral health and developmental disabilities services that lead to a life of recovery and independence. To support the necessary legal mandates of the Belton Consent Order, ODS also employs a Business Operations Analyst and an Administrative Assistant. To assist with the Consent Order compliance processes and project management, DBHDD also provides ODS with a part-time Project Manager. Statewide, ODS has 1 full-time and 17 PRN interpreters trained specifically to provide sign language interpretation in mental health and developmental disability settings. In addition, we have two ASL-fluent Communication Assessors and are currently trying to hire an additional three more ASL-fluent Communication Assessors to provide professional communication assessments of language access needs for the people we serve across the state. Finally, ODS has developed a contract with a DBHDD Community Service Board, Avita Community Partners, to develop and maintain sufficient numbers of ASL-fluent Therapists and Case Managers both in-person and via telemedicine to provide linguistically accessible and culturally competent services to this vulnerable population across Georgia. ODS works closely with the Division of Developmental Disabilities to partner with a community non-profit to provide ASL instruction and training to those providers who are serving individuals who have a hearing loss and communicate in sign language.

The Office of Recovery Transformation (ORT) has its roots in the former Office of Consumer Relations which was formed in 2000. Under the leadership of its Director (a Certified Peer Specialist) and through the work of an Assistant Director, and in collaboration with staff from other Offices, ORT brings the voice of lived experience from adults and youth in recovery from mental and/or substance use disorders, as well as parents of youth with SED and/or other behavioral health conditions, to inform, guide and support DBHDD's transformation to a Recovery Oriented System of Care (ROSC). ORT partners with an internal steering committee of DBHDD leadership as well as the Georgia Recovery Initiative, a group of community advocates, providers, and people in recovery, to exchange information, vet ideas and inform their work. While recognizing the seven building blocks of a ROSC, the ORT is currently focused on aligning behavioral health treatment with a recovery-orientation; increasing understanding about how to partner with Certified Peer Specialists to integrate their unique and valuable contributions into the behavioral health care system; advancing the development of the Certified Peer Specialist workforce; and developing grass roots leadership to mobilize and activate local recovery communities that offer education about and connection to treatment and recovery resources for mental and substance use disorders.

The **Office of Federal Grant Programs and Cultural and Linguistic Competency** (OFGP/CLC) is an office that focuses on management of federally-funded and other grant programs, DBH special initiatives, and as of September 2019 the Office has been tasked with further developing the DBH infrastructure/framework for cultural and linguistic competency and coordinating related training and technical assistance internally and externally for DBH contracted providers. The Community Mental Health Services Block Grant (MHBG)and the Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Grant are managed/co-managed through OFG/CLC. In addition, the Director of this office provides management support and oversight for DBHDD's partnership with the Department of Public Health on the SAMHSA Project LAUNCH grant. Currently, there are two programmatic staff in this office: First Episode Psychosis Project Coordinator, and the Young Child Wellness Partner for Project LAUNCH. The Director also works collaboratively within DBH to ensure successful implementation of any other grant goals and objectives. In addition, she provides staff support to the Behavioral Health Planning and Advisory Council (BHPAC) for the MHBG.

The **Office of Field Operations (OFO)** for behavioral health is an integral part of the Division of Behavioral Health team. The Director of Field Operations (DFO) leads this office and is responsible for overseeing and managing the efforts of six regional field offices, each lead by a Behavioral Health Regional Services Administrator (RSA). The RSA is responsible for overseeing the local systems of community-based behavioral health (BH) services for their respective region with help approximately six direct reports.

The Director of Field Operations directs the day-to-day operations for the OFO for Behavioral Health to ensure continuity related to the Division of Behavioral Health at the regional level. The Director serves as an advisor to DBHDD on a wide variety of complex issues, including statewide and inter-regional issues. The Director ensures service needs identified by the Regional Field Offices and Regional Advisory Councils are submitted to DBHDD in order to inform them on issues that could affect policy, strategic planning, and the budgetary process. Additionally, the position develops and maintains effective working relationships with stakeholders statewide advocating for maximum integration of services and/or functions between community and state hospital systems to ensure seamless continuity of care for consumers and utilization of appropriate referral processes.

The **Office of Crisis Coordination** is an enterprise Office designed to look at the crisis system from a high level and make recommendations to programmatic leaders for system change and improvement. With purview into the Division of Developmental Disabilities, Division of Behavioral Health, and the Division of Hospital Services, the Director of the Office of Crisis Coordination works to ensure the appropriate data and trends are analyzed to equip leaders in

making capacity, quality, and system decisions. The office works with the Divisions to create cross-communication and programming to meet the needs of all individuals served through DBHDD.

This Office is also responsible for the oversight and enhancements to the crisis live referral board. The most recent updates have been funded in part through a TTI grant through NASMHPD. The Georgia Crisis and Access Line (GCAL) manages the platform and provides electronic monitoring of all individuals who need placement in the crisis system as well as a live census of bed availability across the system.

DBHDD Regions

The DBHDD system of services is administered through 6 Field Offices that serve Georgia. These offices administer the hospital and community resources assigned to the region. The regional field offices are first point of contact for any questions about local services. The regional field offices are responsible for: 1) locating and coordinating services and supports; 2) monitoring the services being received by consumers to ensure quality and access; 3) developing new services and expanding existing services as needed; 4) investigating and resolving complaints; 5) conducting special investigations and reviews when warranted; and 6) overseeing statewide initiatives. Regional Offices are the administrative offices of the Department, responsible for the implementation and administration of the plans, policies, and directives issued by the Department.

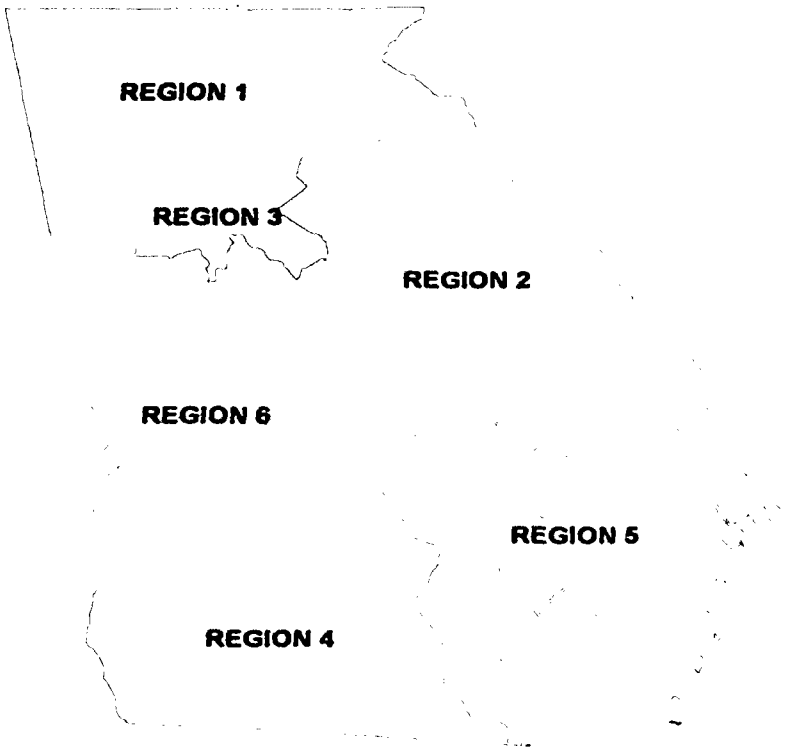
The Regional Field Offices ensure that services brokered by DBHDD are implemented and provided according to design "Easy access to high-quality care that leads to a life of recovery and independence for the people we serve." These Offices support the network of providers in their regions to assure a full array of services and supports to individuals needing publicly funded services. Each Field Office is managed by a Regional Services Administrator (RSA). These RSA's develop and maintain effective working relationships with all stakeholders in the Region through regular meetings with providers, consumers, family members, advocates, elected officials, and other social services agencies. Under broad supervision of the Director of Field Operations, the Regional Service Administrators are responsible for managing and overseeing a system of community-based Behavioral Health services for the regions. This means working closely with Regional Advisory Councils (RAC), local community collaboratives, providers both in and out of network, DBHDD Central Office, the Director Field Operations, and their counterparts across the state to assure continuity and quality of services across regions Referenced earlier was the partnership/meetings each region has with the Regional Advisory Council (RAC). Specifically, the role the RAC plays with each Field Office is to promote public awareness of mental health, developmental disabilities, and addictive diseases disorders, and to help the public better understand individuals and their needs and services. RAC members stay informed about local needs and issues, and serve as advocates with public officials. The

main objective of the RAC is to assist the department in fulfilling its vision of "easy access to high-quality care that leads to a life of recovery and independence for the people we serve." These advisory councils are required to have at least 50% of their membership comprised of consumers and family members to assure the inclusion of the consumer/family voice in determining needed services for the local region.

Listed below are examples of some specific duties and/or functions of the Field Offices; however, not meant to be all inclusive:

- Responsible for managing and overseeing a system of community-based Behavioral Health services for the region, ensuring accountable and effective continuum of care to support Georgians with behavioral health challenges, and intellectual and developmental disabilities in a dynamic health care environment
- Manages and collaborates with State Office staff and the Georgia Crisis Response System for the Region, closely follows/ensures implementation of all Department regulations, directives, and polies.
- Responsible for supervision of regional office staff members' performance of various duties including assisting hospitals, providers, Beacon, GCAL, the ASO, and consumers in implementation of person-center community transition plan; in addition to, resolving consumer and other constituent complaints.
- Facilitate Regional Community Collaborative and Crisis Meetings
- Provides support and assistance to regional advisory councils (RAC) and assisting in the development of annual plans that identifies and prioritizes the needs in the region
- Actively participate in the strategic planning for the Region and ensure local representation of the plans and related implementation strategies
- Partner with other DBHDD Divisions collaboratively to ensure well versed knowledge around current initiatives projects, new program development and policies; ensure effective communication aforementioned to ensure continuity, shared understanding and consistency in execution

The map below shows the location of DBHDD's six regions. The division of Georgia's 159 counties into the six regions is shown after the map.



Region 1 Field Office serves the following 31 counties in North Georgia: Banks, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Hart, Lumpkin, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, White, and Whitfield.

Region 2 Field Office serves the following 33 counties in East Central Georgia: Baldwin, Barrow, Bibb, Burke, Clarke, Columbia, Elbert, Emanuel, Glascock, Greene, Hancock, Jackson, Jasper, Jefferson, Jenkins, Jones, Lincoln, Madison, McDuffie, Monroe, Morgan, Oconee, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Twiggs, Walton, Warren, Washington, Wilkes, and Wilkinson.

Region 3 Field Office serves the following 6 counties surrounding Metro Atlanta: Clayton, DeKalb, Fulton, Gwinnett, Newton and Rockdale.

Region 4 Field Office serves the following 24 counties in Southwestern Georgia: Baker, Ben Hill, Berrien, Brooks, Calhoun, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Seminole, Terrell, Thomas, Tift, Turner, and Worth.

Region 5 Field Office serves the following 34 counties in Southeastern Georgia: Appling, Atkinson, Bacon, Bleckley, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Dodge, Effingham, Evans, Glynn, Jeff Davis, Johnson, Laurens, Liberty, Long, McIntosh, Montgomery, Pierce, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Ware, Wayne, Wheeler and Wilcox.

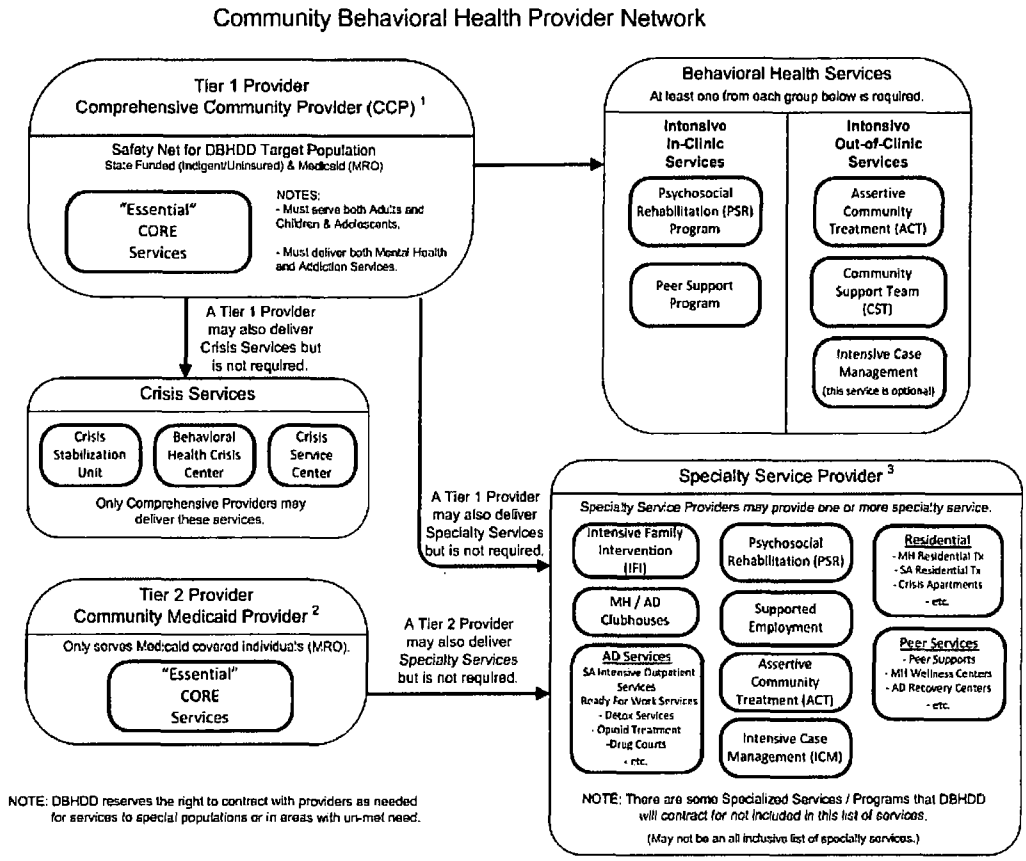
Region 6 Field Office serves the following 31 counties in West Central Georgia: Butts, Carroll, Chattahoochee, Clay, Coweta, Crawford, Crisp, Dooly, Fayette, Harris, Heard, Henry, Houston, Lamar, Macon, Marion, Meriwether, Muscogee, Peach, Pike, Quitman, Randolph, Schley, Spalding, Stewart, Sumter, Talbot, Taylor, Troup, Upson and Webster.

DBHDD Community Providers

DBHDD is responsible for the delivery of services for adults and youth with mental illness, substance use disorders, co-occurring disorders, children with serious emotional disturbances, as well as for people with intellectual and developmental disabilities. The service delivery system and the process for developing and contracting with providers are comprehensive in scope and focused on the value of consumer choice. Community-based services are delivered by a network of private and public providers with whom DBHDD contracts or has letters of agreement. Currently there are over 250 behavioral health providers for DBHDD with 24 of them being Community Service Boards, the public safety net providers.

To establish an effective and accountable continuum of care that is sustainable in a dynamic health care environment, DBHDD implemented three major initiatives directly impacting the provider network, with the intent and expectation that these initiatives would result in higher quality services, statewide consistency, and improved accountability for both providers and the Department's management of community operations. These initiatives included 1) Core Re-design, 2) Georgia Collaborative Administrative Services Organization (ASO), and 3) restructuring of the agency at the state and regional level (described above).

The **Core Redesign** was implemented to improve access, quality, efficiencies, and fiscal accountability within the community behavioral health provider network. Providers in the Department's Community Behavioral Health Provider Network are categorized as shown in the chart below and the tier descriptions that follow the chart.



Tier 1: Comprehensive Community Providers (CCP) - CCPs function as the safety net for the target population, serve the most vulnerable and respond to critical access needs. The designation of safety net providers (CCPs) is an important step for the system in creating a standardized public benefit across all counties which is accountable and transparent to recipients of services, their families and supporters, and payers. More specifically, CCPs, which are Community Service Boards (CSBs), are DBHDD public providers who operate within a recovery-oriented system of care that has the capacity to deliver comprehensive and vital community mental health and substance use disorder services to identified Georgians. Tier I CCP providers have the unique capacity and infrastructure, including comprehensive staffing and electronic information systems capability, to provide a seamless continuum of behavioral healthcare, without need for multiple referrals and coordination. These providers serve as the clinical home for individuals enrolled in services and receive DBHDD state funds to support infrastructure needed to be a safety net provider. Safety-net providers also typically see a mixture of individuals who are uninsured, as well as insured, on Medicaid, or privately insured.

Each CCP must have the capacity to provide a core benefits package for individuals for whom the service is deemed clinically appropriate. Mental Health/Substance Use Disorder services

include behavioral health assessment/service plan development, psychological testing, diagnostic assessment, crisis intervention, psychiatric treatment, nursing assessment and health services, medication administration, pharmacy and lab services, community support /case management/PSR-1, and individual/group/family outpatient services, addictive disease support services, and peer support. A CCP must also provide at least one intensive in-clinic service such as psychosocial rehabilitation or peer support program and one intensive out of clinic service such as assertive community treatment, community support team or intensive case management. A CCP may also offer other crisis and specialty services such as intensive case management, psychosocial rehabilitation, supported employment, assertive community treatment, residential services, peer services, resiliency support clubhouses, intensive family intervention, community based inpatient psychiatric and substance detoxification services, crisis stabilization unit, behavioral health crisis center, crisis service center, and addictive disease services.

Tier 1 providers operate under 12 CCP Standards. These standards include access to services; crisis management; transitioning of individuals in crisis from inpatient and crisis stabilization care; engagement in care; substance use treatment and supports; recovery oriented care; administrative and fiscal structure; required staffing; accreditation, certification and licensing; benefits eligibility; suicide prevention; and access to housing.

Tier 2: Community Medicaid Providers (CMP) - CMPs provide behavioral health services and supports identified in the Medicaid State Plan for adults, youth, and young adults with a mental health condition or Substance Use Disorder (SUD). A CMP may be age-focused (i.e. only children and adolescents or only adults, or both). A CMP offers the essential core benefit package of services and is **required** to operate in compliance with the CMP Standards as well as all contract or Letter of Agreement (LOA) and Provider Manual requirements. A CMP may also offer specialty services but is not required. CMPs also follow standards that closely resemble Tier 1 standards.

Tier 3: Specialty Providers (SP) – Specialty Providers may provide one or more specialty services: Assertive Community Treatment, Intensive Family Intervention, MH & AD Clubhouses, Peer Services, Psychosocial Rehabilitation, Supported Employment, Intensive Case Management, Addictive Disease Specialty Treatment, Residential Services and Peer Services.

As mentioned above, Community Service Boards are the established public providers of mental health, developmental disability and addictive disease services, the designated safety net providers and are therefore classified as Tier 1 CCPs. The provider network also includes private provider agencies offering core services as well as a variety of specialized services as Tier 2 and Tier 3 providers.

Through a standardized provider application process, organizations are encouraged to apply to become authorized providers to increase consumer choice. All Behavioral Health providers under contract with DBHDD must adhere to the Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Behavioral Health, which includes core requirements and utilization guidelines for all providers. The requirements identified in the manual assure that an organized and standard system of care is available to citizens of Georgia wherever they live in the state and according to individual need. Services are required to be provided in a culturally appropriate and competent manner by providers with a workforce trained to recognize and address diverse needs. All Providers must be accredited at the time of application and continuously recredentialed by one of the following organizations: The Joint Commission (TJC), the Council on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the Council on Quality and Leadership (CQL).

DBHDD Administrative Services Organization

The Georgia Collaborative ASO (ASO) is the administrative services organization (ASO) for DBHDD. The ASO provides administrative services in support of Georgia's public, integrated behavioral health and intellectual/developmental disability service system. The ASO provides these supports for adults and children who are eligible for fee-for-service Medicaid and those who are uninsured, as well as and individuals with IDD. Operating as the Georgia Collaborative ASO, three companies partner together as a Collaborative vendor including Beacon Health Options, Behavioral Health Link (BHL), who provides telephonic crisis intervention, and preferred single-point-of entry services and mobile crisis dispatch as the Georgia Crisis and Access Line (GCAL), and Q'larant (formerly the Delmarva Foundation), who provide quality reviews and trainings for DBHDD contracted providers who serve individuals with IDD. The goal of the partnership is to improve coordination, increase efficiency and support high-quality care for individuals served by the department.

Some highlights of the Collaboratives' functions include:

- Maintaining the 24/7 Georgia Crisis and Access Line for behavioral health and developmental disability services
- Deploying integrated information technology system for behavioral health and developmental disabilities
- Using state-of-the-art technologies to create efficiencies and improve the quality of care
- Quality management and consultation for all behavioral health and developmental disability providers
- Providing focused utilization management and review services

MENTAL HEALTH SERVICES SYSTEM DESCRIPTION

Following are descriptions of the Adult Mental Health and Child and Adolescent Mental Health systems organized by Criterion required for the Mental Health Block Grant application. Three criteria are included for the adult description in this section: Criterion I: Comprehensive Community-based Mental Health Service System; Criterion IV: Targeted Services to Rural, Homeless, Older Adult and special populations; and Criterion V: Management Systems of Human and Fiscal Resources. Four Criteria are included for the child and adolescent description: Criterion I: Comprehensive Community-based Mental Health Service System; Criterion III: System of Integrated Services, Criterion IV: Targeted Services to Rural and Homeless; and, Criterion V: Management Systems of Human and Fiscal Resources. One additional criterion, Criterion II: Mental Health System Data Epidemiology is discussed in a separate section on Unmet Needs for adults, children and adolescents.

ADULT MENTAL HEALTH

Criterion I: Comprehensive Community-based Mental Health Service Systems

Georgia provides a comprehensive community-based system of mental health care for adults with serious mental illness who need public services. An array of community based mental health services is provided in each service area of the state, including evidence-based practice services identified as most effective for individuals with serious mental illness. While not all services are available in every one of Georgia's 159 counties, each county is included in one of the state's 25 service areas. The array of services is provided in the lead counties of the services areas, at a minimum, with some services available in satellite offices or through mobile service delivery. Additionally, the state continues to enroll core providers throughout the state to allow for consumer choice among service providers. Consumer choice is a transformation project that has empowered consumers and shifted providers' expectations about how they need to provide services in order to attract consumers.

Georgia continues to advance evidence-based practices and promising practices. DBHDD has focused considerable attention on developing and implementing evidence-based practices within the mental health service system through dissemination of information and through pilot demonstration projects. As a result of this emphasis on best practice, the mental health system in Georgia has implemented Evidence-Based Practices (EBPs) in various parts of the state. The EBPs used within the state include Assertive Community Treatment (ACT), Individual Placement and Support (IPS) Supported Employment, Motivational Interviewing (MI), Housing First Permanent Supported Housing, and Integrated Dual Diagnosis Treatment (IDDT). In addition, Georgia has been a leader in the development of Peer Support Services and has implemented a Forensic Peer Mentor initiative. DBHDD also contract for the delivery of an

array of crisis services. All of these services provide a system of care for adults, support recovery of individuals and provide opportunities for a meaningful life in the community.

With an increased emphasis on growing our community system, and insuring that individuals can access the services and supports needed to experience the highest quality of life possible in the community, the DBHDD has expanded the delivery of services across the state, to include increased numbers of persons served in Supported Employment, expanded the array of crisis services including increased crisis respite apartments and behavioral health crisis centers, and expansion of behavioral health accountability courts.

Of significance to Georgia, the Department of Justice filed a separate lawsuit against the State, DBHDD and the Department of Community Health (DCH) alleging violations of the American with Disabilities Act (ADA). DOJ alleged that Georgia failed to "administer services in the most integrated setting appropriate to the needs of qualified individuals with disabilities". The Governor and the two Commissioners signed a Settlement Agreement which was entered by the court on October 29, 2010. The settlement agreement addresses consumer rights related to safety and effectiveness of state operated psychiatric hospitals. It primarily addresses the provision of increased community-based services under the ADA and in accordance with the US Supreme Court's Olmstead decision. Under the settlement agreement, a target population is defined; 9,000 persons with severe and persistent mental illness who are currently being served in state operated hospitals; frequently readmitted to state operated hospitals; frequently seen in emergency rooms due to mental illness; chronically homeless; and/or released from jails or prisons. Georgia is required to provide expanded and enhanced community services for target population individuals via any of the following services include Assertive Community Treatment (ACT), Community Support Team (CST), Intensive Case Management/Case Management, Supported Employment, Crisis Respite Apartments, Supported Housing, and an array of crisis services. Georgia implemented and is sustaining all of the required behavioral health treatment services, and achieved compliance with those behavioral health treatment services targets in the fall of 2016. One remaining behavioral health non-treatment program- Supported Housing, remains in the Settlement Agreement Extension, which was signed in the fall of 2016 and scheduled to end 6/30/18. The following targets were achieved:

#	New Adult Mental Health Community-Based Services Description
22	Assertive Community Treatment Teams
10	Community Support Teams
14	Intensive Case Management Teams
52	Case Management Services
3	Crisis Stabilization Programs
10	Behavioral Health Crisis Centers

4,054	Persons receiving state funded Supported Housing
4,342	Persons receiving Bridge Funding
1,200	Persons receiving Supported Employment Services
835	persons receiving Peer Support Services
18	Crisis Respite Apartments
159	Counties with Mobile Crisis Service coverage

An independent Reviewer and multiple subject matter experts chosen jointly by the state and DOJ routinely evaluate the state's compliance with the terms of the settlement agreement and produce reports to the Court twice a year.

Assertive Community Treatment

DBHDD currently contracts with providers for statewide delivery of ACT services in all 6 regions in the state of Georgia with funding and support for 22 state contracted and four Medicaid Rehabilitation Option (MRO) teams. In addition to financial support, the ACT teams also receive from the state office technical assistance and guidance from the DBHDD three-member ACT and CST Services Unit. Annually, this team completes a fidelity review for each of the 22 contracted and four MRO teams utilizing the Dartmouth Assertive Community Treatment Scale to ensure that all ACT teams in the state of Georgia are operating with fidelity to this model. Throughout the year, ACT teams receive consultation from the ACT and CST Services Unit as well as several training initiatives which were provided by DBHDD through national experts and consultants. Training topics included the following: transition planning, Integrated Dual Disorder Treatment, Collaborative Documentation, Recovery-oriented Cognitive Behavioral Therapy, Recovery Oriented System of Care, Dialectical Behavior Therapy, Motivational Interviewing, Disaster Preparedness, Self-Care, Effective Team Leadership, Trauma Informed Community Based Service Delivery, and Housing First Model Training. At the conclusion of the annual fidelity reviews for all ACT teams DBHDD initiated a fidelity roundtable discussion, allowing a forum for provision of feedback and input from all providers about the review process and overall ACT operations. ACT Coalition meetings are conducted bimonthly and are held in a central location of the state. All ACT providers throughout the state are able to attend the meeting in person, access the meeting via conference telephone line and/or use a video access line where they can view the meeting live online. ACT Coalition meetings provide a forum for distribution of relevant information and receipt of feedback from providers. During coalition meetings there are also presentations on various topics that are useful in the delivery of the ACT services. Presentations in the past have included but are not limited to strategies for ACT teams to assist individuals in obtaining benefits and/or employment, housing resources and options for homeless individuals, ACT team collaboration with local jails, engagement strategies, and delivery of Substance Abuse treatment within the ACT model. Additionally, the ACT and CST Unit facilitates role-specific support calls for members of the

team to share best practices within their scope of work with others in the same role across the state. These calls typically take place monthly.

Employment Services

Supported Employment Services

A portion of Georgia's MHBG allocation funds the capacity to provide Supported Employment (SE) services to over 2200 adults with mental illness each month. In addition to MHBG funding we allocate state funds for Supported Employment for individuals that are identified under the ADA Settlement Agreement as meeting criteria for serious and persistent mental illness (SPMI) which supports SE service for 570 individuals; DBHDD's contracted SE providers are now funded to serve 2,790 individuals each month. Also, in FY17 the Office of Children, Young Adults and Families provided funding inclusive of 105 slots to serve Transition Aged Young Adults ages 18-25.

The increase in SE services also provides the department the opportunity to continue to implement provider training on evidence-based practice SE (EBP SE) also known as the Individual Placement & Support (IPS) Model. In FY19 and continuing into FY20, DBHDD provided training via SE Provider Coalition meetings; and by funding scholarships to the Statewide GA-APSE conference, SE Supervisor Retreat, and 5 IPS Webinar Series for SE supervisors and Employment Specialists. Technical assistance was also provided during onsite IPS fidelity reviews of DBHDD's contracted providers.

In FY19 and continuing into FY20, DBHDD will continue to require SE Providers to submit a monthly SE programmatic report, which is used to calculate payment as well as track compliance with contract deliverables, quality performance measures, and fidelity to the IPS model. Collected data was used to support determination of funding allocations as well as training and technical assistance needs.

DBHDD continues our partnership with the Georgia Vocational Rehabilitation Agency (GVRA), Vocational Rehabilitation program (VR). Both agencies continue to work in a more coordinated and efficient manner, in accordance with federal and state regulations to provide EBP SE services and support more individuals with SPMI in meeting their vocational and employment goals. In FY19, the Georgia IPS Initiative has currently to date provided services to 3100 dually enrolled persons benefitting from DBHDD Adult Mental Health IPS Supported Employment and VR Employment services. We currently have 1133 actively dually enrolled.

CMS has approved DBHDD's use of Task Oriented Rehabilitation Services (TORS), originally proposed as Employment Rehabilitation Services. This service has been fully implemented and available to all DBHDD state contracted SE Providers. DBHDD state office staff continues to ensure that this service correlates with the SE service definition to reflect IPS fidelity standards.

Supported Housing

DBHDD seeks to empower people to overcome barriers to obtaining permanent housing, which includes access to the right kinds of supports and care to get and keep their housing, and improve their quality of life—some individuals benefit from intensive services and structured programs, while some individuals benefit from housing support programs aimed at assisting them to afford housing without the intensive, program-based treatments supports that others need to remain housed. All of these programs make up a continuum of housing programs aimed at empowering individuals to achieve and remain stably housed as in recovery.

The continuum of residential services model allows DBHDD to focus on matching the right level of housing supports and services to people's needs and strengths. There are some who might just need long-term rental assistance or affordable housing coupled with case management supports; others may need more intensive residential supports that allow them to remain in the community. A responsive and capable supported housing continuum provides housing and services supports at these ends of the spectrum, as well as those levels of housing programs of support and services in between.

The idea that some of the programs within the DBHDD Supported Housing Continuum sometimes require "intensive" services should not be taken to mean that the focus of services is only on therapeutic or treatment goals. In fact, the DBHDD Supported Housing Continuum emphasizes services and supports that focus on housing stability and using housing stability as a platform for connecting people to the types of services and care that they seek for gains in health, recovery, and well-being. Housing is considered to be so key to a person's health, recovery, and well-being that some "intensive" types of housing-based, residential services are needed within a continuum of care to increase the stability and focus on housing as the platform for stability and advancement in other areas of life. In this way, DBHDD's Supported Housing Continuum is based on the premise that people need to have available to choose from different levels of housing supports and programs that will allow them success in health, well-being, and recovery to achieve stability in their housing, which then is the basis for other gains in their recovery.

The DBHDD Supported Housing Continuum is—first and foremost—about health and well-being. The DBHDD Supported Housing Continuum is built upon and emphasizes choice among different levels of housing support intensity to meet their recovery goals. DBHDD recognizes that health and recovery are so much more attainable when people have a safe and stable home with options for individuals to have the level of services supports and intensity that affords them the freedom of how they progress in their recovery.

DBHDD began using results-oriented program evaluation for the supported housing program in 2019.
DBHDD considered several program evaluation theories and approaches, and DBHDD specifically chose a program evaluation theory- and evidence-based approach that is purposefully used by management to achieve measurable indicators of performance and progress towards program outcome objectives related to program goals (Shadish, et al., 1991). Wholey's program evaluation theory and approach emphasizes the following, which are key to improving and developing the DBHDD supported housing program:

- •Utilization of program evaluation approaches that emphasize action and change based on accumulation of knowledge;
- •Target audience of the evaluation is managers that are focused on program performance and improvement;
- •Pragmatic approach to solving problems through incremental and accumulated improvements;
- •Produces valid, objective knowledge to develop and manage programs to achieve desired outcomes;
- •Program evaluation information and processes that assist in moving the program to be prepared to be managed for results;
- •Focuses management attention on providing specific goals that bear on actual activities, to which management is willing to indicate accountability; and
- •Program evaluation information is part and parcel not only to program operations but also program improvements.

In order to be successful, DBHDD has established timelines and processes for reviewing and comparing against baseline and performance targets for process and outcome indicators. Every six months, upper management reviews process monitoring information and data to ensure the program is upholding the principles of supported housing by providing the critical elements of the model.

As of August 2019, DBHDD has adapted SAMHSA fidelity scale and general organizational index has critical tools for this component of the performance monitoring system, and these tools are consistent with basic guidelines for program evaluation.
•Additional information about the program and the people who participate in the program is also reviewed to provide a fuller picture of how the program works to meet the goals of supported housing and individuals in supported housing.

As indicated by SAMHSA, the scales and tools (that DBHDD adapted) were designed and based on an ideal supported housing program, and it is not expected that supported housing programs score the perfect score of 28. However, a score of at least 21 or 75% is necessary to achieve

fidelity. This information will be taken into consideration as DBHDD evaluates and establishes performance targets based on the adapted, modified performance monitoring scale.

In FY08, the Department of Community Affairs (DCA) and DBHDD entered into a partnership to expand access to housing resources for homeless individuals with behavioral health disabilities. The two Departments have been working cooperatively to establish supported housing programs and assist eligible individuals in obtaining and maintaining safe, affordable, independent housing. DCA provides many financing programs to develop housing and DBHDD provides the services and supports needed to assist people in remaining in their communities of choice. DBHDD continues to strengthen partnerships that can increase the availability of permanent supported housing for those with serious mental illness who are homeless.

Georgia settled with the Department of Justice under the Americans with Disabilities Act. As part of the agreement, DBHDD operates a housing voucher program targeting persons with serious and persistent mental illness transitioning out of institutional settings and those who are chronically homeless.

The 2018 Annual Homeless Assessment Report (AHAR) to Congress identified Georgia as one of the highest rates of unsheltered chronically homeless at 76% (992 – homeless and 754 unsheltered). According to the AHAR, 9 in every 10,000 people experience homeless with a total of 9,499 total homeless in Georgia with 6,943 individuals and 2,556 people in families with children. Supported housing is recognized as a national evidence based best practice by SAMHSA aimed at providing cost savings to states by supporting chronic populations that are high utilizers of services who often cycle frequently through various public institutions at great cost to taxpayers. Within the State of Georgia, access to the DBHDD Georgia Housing Voucher and Bridge funds allows the most chronic population of adults with severe and persistent mental illness to access the supports and services that promote housing stability. Thereby reducing the frequency with which this population of individuals uses other state resources. Stable housing has been linked to reduction of legal involvement/crime and hospitalization. Access to the GHV and Bridge funds allows one of the most vulnerable disabled populations in our state – those with severe and persistent mental illness (SPMI)-- affordable housing with the supportive services necessary to reduce individual's admission to state psychiatric hospitals, emergency rooms, and jails/prisons.

In FY 2017, DBHDD and DCA expanded their MOU and created a shared position to cooperatively advance the collective housing efforts of both agencies. The Supported Housing Program will move forth the goals of supporting providers of both housing and residential services as well as meeting and sustaining the supported housing requirements of the Settlement Agreement Extension. This includes, increasing access to supported housing for our target population, maximizing state resources for supported housing for our target population,

operationalizing a statewide unified referral process for supported housing, and continuing the work of oversight of the statewide supported housing need and choice survey. This unit will work in collaboration with the DBHDD and DCA regional field offices, community BH providers, hospitals, state and local agencies and law enforcement to support comprehensive implementation of strategies that will promote supported housing access statewide.

In response to the Settlement Agreement the Department implemented the Need for Supporting Housing Survey (NSH) to assess the need for supported housing for individuals meeting DOJ settlement criteria. As of August 2019, the Need for Supported Housing (NSH) reports that 61% of individuals (1328) were in need of supported housing.

The FY 2018 Georgia PATH Annual Report indicates that 4,500 people were contacted by the PATH program. Of those contacted, 2,545 were actively enrolled in PATH with 52% chronically homeless and 57.8% with a primary mental health diagnosis with no substance use co-occurring disorder.

DBHDD is currently partnering with state and local re-reentry initiatives to ensure that those with serious mental health needs being released from jails/prisons have access to community-based services and supported housing.

Supported Housing Accomplishments include:

- Since inception of the US DOJ vs GA Settlement Agreement, 4,757 individuals served by the Georgia Housing Voucher.
- Across the state, the Department contracts for PATH services (Projects for Assistance in Transition from Homelessness), these are teams of case managers whose sole focus is to work in communities across the state connecting homeless persons who have behavioral health needs with housing and services.
- Each year of the Settlement agreement, the Department has exceeded the #s of persons required to be served via the GHV and Bridge programs because we know that stable housing is integral to achieving a life of independence and recovery.
- DBHDD is now one of the largest subsidized rental subsidy programs in the state.
- As important as it is to assist individuals in obtaining safe and stable housing, it is equally vital to offer the supports and access to services that will help someone maintain their housing. This is the beauty of our system; DBHDD has a network of dedicated, hardworking behavioral health community service providers who deliver Community Support Team (CST) and Assertive Community Treatment (ACT) and Intensive Case Management (ICM) for persons with serious mental illness, supporting people with skills building and recovery planning in a way that helps people remain stable and housed in their community.

- The GHV program has a housing stability rate of 94%, meaning, a very high number of individuals who are living in supported housing apartments funded by the GHV remain stably housed for 6-months or more.

Peer Support Services

A portion of Georgia's MHBG allocation funds the capacity to provide peer supports. Georgia's Peer Support Services are led by Certified Peer Specialists who promote recovery, wellness, socialization, self-advocacy, development of natural supports and life goals, and maintenance of community living skills. Activities facilitated between peers must promote self-directed recovery by exploring consumer purpose beyond the identified mental illness and possibilities of recovery; tapping into consumer strengths related to illness self-management; emphasizing hope and wellness; and by helping consumers work toward achievement of specific personal recovery goals, which may include meaningful employment; and by assisting consumers with relapse prevention planning. CPSs have been trained in the essential skills of peer mentoring/coaching including active listening, motivational enhancement, and how to use their personal recovery experience to encourage and support others.

Georgia offers an array of Peer Support Services. Peer Support Programs provide structured group activities that are provided between and among individuals who have common issues and needs; are consumer motivated, initiated and/or managed; and assist individuals in living as independently as possible. A Peer Support Program may be a stand-alone center or housed as a "program" within a larger agency, and must maintain adequate staffing support to enable a safe, structured recovery environment in which individuals can meet and provide mutual support.

Agencies that operate Peer Support Programs and Tier I and Tier II providers may also provide Peer Support Services – Individual, in a 1:1 modality between a CPS and a person served. Individuals participating in the service must have the opportunity, at any given time, to participate in and make decisions about the person-centered interactions offered by the Certified Peer Specialist/s. Individuals should set their own individualized goals and assess their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Goal attainment should be supported through a myriad of approaches (e.g. coaching approaches, assistance via technology, etc.). This service may be provided in the clinic or community.

Peer Support Whole Health & Wellness is provided in a 1:1 modality between the person served and a CPS with additional certification as a Whole Health & Wellness Coach. Whole Health and Wellness Coaches have additional training in whole health wellness, relaxation response techniques, mind-body interventions, nutrition, stress management and smoking cessation. A designated nurse provides consultative support to Whole Health and Wellness Coaches who assist individuals with setting personal expectations, introducing health objectives as an approach

to accomplishing overall life goals, helping identify personal and meaningful motivation, and health/wellness self-management. The individual served is supported to be the director of his/her health by identifying incremental and measurable steps/objectives that make sense to the person. Health engagement and health management for the individual are key objectives of the service. These should be accomplished by facilitating health dialogues; exploring the multiple choices for health engagement; supporting the individual in overcoming fears and anxiety related to engaging with health care providers and procedures; promoting engagement with health practitioners including, at a minimum, participating in an annual physical; assisting the individual in the work of finding a compatible primary physician who is trusted; among other engagement activities. Another major objective is promoting access to health supports. This is accomplished by using technology to support the individual's goals; providing materials which assist in structuring the individual's path to prevention, healthcare, and wellness; partnering with the person to navigate the health care system; assisting the person in developing his/her own natural support network which will promote that individual's wellness goals; creating solutions with the person to overcome barriers which prevent healthcare engagement (e.g. transportation, food stamps, shelter, medications, safe environments in which to practice healthy choices, etc.); and linking the individual with other health and wellness resources (physical activity, fitness, healthy/nutritional food).

The above 3 types of Peer Support services are Medicaid-billable and provided across the state by behavioral health service providers. Georgia also offers specialized Peer Support Services via a contract with the Georgia Mental Health Consumer Network, a consumer-operated agency that is Georgia's largest employer of individuals in recovery from mental illness. These services include 5 Peer Wellness and Respite Centers and a Peer Support Warm Line.

Double Trouble in Recovery (DTR) is a 12-step self-help recovery support group for individuals with co-occurring mental health and substance use disorders. GMHCN trains DTR group leaders and coordinates sixty weekly DTR meetings across the state. Meeting locations include State Hospitals, Mental Health and Drug Courts, Department of Corrections Day Reporting Centers, Behavioral Health Treatment Centers, Residential Programs, medical centers, churches, and public libraries.

The GMHCN Peer Mentor Program offers one-on-one peer support services provided by CPSs to facilitate individuals' transition from long-term hospitalization to community living; or support individuals who frequently utilize Crisis Stabilization services to increase connection to community services and supports. Two half-time Peer Mentors are assigned to each of the six DBHDD regions to engage with interested individuals and assist them in making informed choices in their transition planning process. This may include taking an individual into the community to meet potential community service providers or explore housing options. Peer Mentors follow individuals into the community for up to two years, to support adjustment to

their new home and service providers; help them explore interests and make linkages with natural supports in the community such as churches, civic groups, etc.; and establish a meaningful daily life. The Peer Mentors advocate for the individuals and teach them to advocate for themselves.

In SFY14 DBHDD increased state funding in GMHCN's contract to open two more Peer Support, Wellness and Respite Centers (PSWRCs), increasing the statewide total to five. The PSWRCs provide an alternative to psychiatric hospitalization by offering free respite services up to a week at a time to individuals who have established relationships with the all-peer staff. The PSWRCs also provide daily walk-in peer support and wellness activities and operate a 24/7 peer support warm line, which can facilitate warm transfers to the Georgia Crisis and Access Line if appropriate.

Forensic Peer Mentor Pilot Project Outcomes
(Apr '15 – May '16)

Facilities staffed = 11

Enrolled = 216

Transition planning sessions = 5,367

Program outcomes
(DRC & Hospital Participants + Post-release from Prison Returning Citizens)

Stable Housing	Avg. 90%
Employed	Avg. 67%
Linked to MH Services	Avg. 73%
Psychiatric hospitalizations	0%
New Arrests	10% *

*Only participant with a new conviction had outstanding warrant that was not resolved during prior prison stay; was convicted on that charge following release.

In SFY15 DBHDD contracted with the GMHCN to develop a pilot Forensic Peer Mentor Program in partnership with the Georgia Department of Corrections (GDC) and the Georgia Department of Community Supervision (DCS). CPSs and/or Certified Addiction Recovery Empowerment Specialists (CARES, aka CPS-AD) were provided 40 hours of additional training to support individuals with behavioral health conditions to successfully transition from incarceration in prison to community living. Individuals identified by behavioral health clinical staff at program sites, who elect to participate, are paired with a Forensic Peer Mentor who offers assistance with self-direction in choice of services and supports; behavioral health care, housing, employment, service providers, etc., in transition planning, and in executing the plan to ensure connection with community services, employment and development of natural supports. In FY19 15 Forensic Peer Mentors provided 12,000 transition planning and support sessions to 479 Returning Citizens in state prisons, Day Reporting Centers (probation/parole), state psychiatric hospital forensic units, and Mental Health Treatment Courts. This table shows program outcomes for the pilot year of the program (April 2015 to May 2016).

Georgia Crisis and Access Line

Via contract with DBHDD, Behavioral Health Link (BHL) operates the Georgia's Crisis and Access Line (GCAL). GCAL's professional, clinical staff provide 24/7 telephonic crisis intervention and linkage to DBHDD services state-wide through a toll-free, confidential hotline available 24 hours a day, 7 days a week from anywhere in Georgia. It connects callers with a trained, professional who can help them get the services they need if they or someone they know or are caring for are in emotional distress, behavioral health crisis, a suicidal crisis, or even a crisis related to an intellectual/developmental disability.

The hotline is staffed by trained and caring professionals who are available around the clock to provide help and hope. The primary goal is to help connect individuals with care quickly, close to home, and to avoid unnecessary law enforcement or emergency department intervention. GCAL receives nearly 1,000 contacts on most business days and makes nearly as many outbound contacts to coordinate care. Nearly 40% are individuals calling for themselves. 16% are calling for their friends or family. A surprising 46% are professionals seeking support for an individual under their care or in their services. Professionals call GCAL from emergency rooms, community mental health centers, private psychiatric hospitals, family and children services, courts, schools, law enforcement, probation and parole, juvenile justice, and many others.

GCAL is the single point of mobile crisis dispatch statewide and serves as the preferred point of entry for Crisis Stabilization Units. As a CARF accredited Crisis and Information Call Center, a URAC accredited Health Call Center and as the only AAS certified crisis center in the State of Georgia, BHL's call center in Atlanta answers over 250,000 calls annually and in 2016 handled over 160,000 distinct episodes of care.

DBHDD and GCAL partnered in 2019 to establish a GCAL text line initiative. Georgia's youth can now access GCAL's services via text and chat through a new app called My GCAL, which became available for download in late January 2019. The app will allow individuals to call, text, or chat with GCAL 24/7/365, choosing how they want to reach out for help.

Recovery Support Services

Recognizing that recovery emerges from hope, and is supported by peers and allies, DBHDD funds a variety of peer support services in group and individual formats, within the formal system of BH care and outside of it, in the community. Within DBHDD's formal system of care, Certified Peer Specialists (CPSs) provide group and one-on-one peer support services, as well as Whole Health & Wellness Peer Support which supports individuals in working toward behavioral and whole health goals. DBHDD requires employment of CPSs on Assertive Community Treatment Teams as well as Mobile Crisis Teams, and encourages utilization of CPSs in the provision of other services for which they're qualified. Through the Recovery-Focused Change Training & Technical Assistance (RFT) initiative with Tier One providers, CPSs have been instrumental in helping provider agencies create a more hopeful and welcoming

climate in waiting rooms of service facilities. In some instances, CPSs are employed as Engagement Specialists, to help orient individuals to the treatment system and understand their rights and responsibilities for participation in treatment services.

When individuals with SMI are hospitalized, they are offered peer support services from a Peer Mentor, who can assist them to actively engage in discharge planning and in making the transition to their new community home. Peer Mentors can help individuals set up household and make solid connections with service providers, and any other groups in the community with whom the individual would like to engage/participate. DBHDD supports individuals in finding housing, and offers housing vouchers to individuals who meet Dept. of Justice Settlement Agreement. DBHDD also offers Supported Employment services for individuals seeking help with employment.

Outside of the formal system, DBHDD funds opportunities for people served to engage in peer support and learn about self-direction, recovery supports, and self-help tools, via the Georgia Peer Support Institute, Annual Consumer Conference, Wellness Recovery Action Plan (WRAP) training and groups, and the Georgia Respect Institute. Five consumer-operated Peer Support, Wellness and Respite Centers offer drop-in wellness activities 7 days a week, respite services for up to 7 consecutive nights, and 24/7 telephonic peer support. Double Trouble in Recovery peer support groups are offered in a variety of community venues for individuals with co-occurring mental and substance use disorders.

DBHDD's long term commitment to developing the peer workforce is paying off in our service system as well as in grass-roots recovery leadership. DBHDD is partnering with the Georgia Council on Substance Abuse and Georgia Mental Health Consumer Network to facilitate, support and nurture the development of local recovery leadership. While the local collaboratives include a variety of community stakeholders including law enforcement, human services, educators, public and private BH providers, faith communities and local businesses, Certified Peer Specialists frequently play key roles in facilitating recovery community dialogues, planning recovery events and creating opportunities for people in recovery to fully participate in their communities.

Transition Services

The Hospital Recovery Planning Teams, Regional Field Office staff and Office of Adult Mental Health Transition Services are responsible for effective transition planning. This planning requires the development of partnerships between individual's hospital staff, field office staff and community care providers. All aspects of person-centered recovery planning rely on shared decision making and individually defined outcomes. Hospital Transition Specialists and Community Case Expediters in the Regional Field Offices are key players who rely on relationships they have established through collaborative efforts to help facilitate individuals

obtaining needed services, and in crisis situations, can often divert individuals from the hospital to appropriate resources in the community. Hospital Transition Specialists and Community Case Expediters are perceived as the link between the hospitals and the community. Each region has Hospital Transition Specialist assigned to work with the state hospital(s) to ensure timely transitions to the community for adult mental health individuals. Hospital Transition Specialists focus on individuals who have been in the hospital over forty-five days and other individuals who face challenges that are barriers to discharge. Community Case Expediters coordinate services for individuals who need assistance navigating the community system of care. Community Case Expediters additionally work with Regional Children, Young Adults and Families (CYF) Program Specialists to ensure coordination of services for young adults leaving hospitals or residential services, who may still qualify to receive Department of Behavioral Health and Developmental Disabilities (DBHDD) supports, Department of Human Services' supports and Public School education.

We recognize the importance of good transition planning to ensure continuity of care for individuals leaving an institutional setting, and we recognize the value of ensuring the individual takes the primary lead for their own recovery and transition activities. Individuals with hospital lengths of stay greater than forty-five days are the focus of intensified transition efforts. Our hospitals are currently using the Individualized Recovery Plan for treatment and transition/discharge planning. Individuals are given the opportunity to participate in planning for their transition with members of their recovery team, the Regional Hospital Transition Specialist, their chosen community care provider, as well as their family members and other stake holders identified by the individual who may play an important role in their life. The planning meeting provides the opportunity to look at the individual's strengths, hopes and desires and what is important to them. This setting provides the venue for identifying barriers, and developing next steps for transition. The team continues to review the transition progress and work through barriers on bi-monthly ADA calls. This process keeps us focused and assures that we recognize and work through barriers. Effective 7/1/2016, DBHDD has implemented policy that ensures contracted community care providers of behavioral health services have a standardized process for assessing an individual's transition needs and incorporating the individual and hospital's recommended services in order to facilitate continuity of care. The Transition Action Plan (TAP) document provides the individual, and community care provider a concise document of the next steps for the individual's continued recovery and successful transition back into the community. In FY16, DBHDD transitioned more than 347 individuals with hospital lengths of stay greater than 45 days from the Adult Mental Health units.

DBHDD has Transitional Coordinators in our Regional Field Offices to help support ADA Settlement Agreement services, such as Community Support Team (CST), Crisis Respite Apartments, Assertive Community Treatment (ACT), Intensive Case Management (ICM), and Supported Employment (SE) etc. to insure timely access to services and to assure appropriate

utilization management. The goal is to have services that support individuals' recovery and allow them to move through the continuum of support services and toward greater independence.

Peer Mentors (with an individual's consent) continue to assist individuals transitioning from institutions to communities. Peer Mentors to assist individuals with identifying community resources, including medical and dental care, employment services, educational services (primarily GED services), support groups, and natural supports. Peer Mentors hold positions at all state operated hospitals.

Georgia's Olmstead Coordinator visits individuals in the state hospitals as well as individuals who have been discharged from the hospital. The Olmstead Coordinator is talking with individuals, hospital region field office staff and community care providers regarding barriers to community living for individuals who wish to receive their services in the community, and have a clinical team recommendation for transition. The Olmstead Coordinator is charged with working with individuals with disabilities, state agencies, advocates and other stakeholders in collaboration with the Olmstead Planning Committee, appointed by the Governor, to develop and implement the State's Olmstead Plan.

Available Services

Georgia's adult mental health state service system includes an array of Core, Specialty, Crisis, and Inpatient services. Adult Mental Health has invested considerable resources to ensure availability of a comprehensive array of intensive, out-of-hospital services including the development of intensive treatment residences, mobile crisis response teams, community based crisis stabilization units, assertive community treatment and community support services, intensive case management as well as psychosocial rehabilitation, peer wellness centers and a host of other community based programming all with the goal of supporting a meaningful life in the community for all of Georgia's citizens.

Consumers and family members may access services by going directly to the provider. For efficiency and convenience, consumers and family members may access statewide Core, Crisis, and Inpatient Services by contacting the Georgia Crisis Access Line. Core Services include a standardized community mental health center type benefit package of behavioral health services that most adults with mental illness would utilize to promote improved functioning and recovery. Specialty Services include those services that adults with more intensive behavioral health needs would utilize based on individual assessed need in order to successfully live in the community. For routine services, the DBHDD statewide Access/Crisis Call Center refers to Core Providers and does not provide direct access to specialty services such as ACT, CST, Residential Services, Psychosocial Rehabilitation, and Supported Employment. The crisis/access call center only refers to Core providers to ensure that individuals' needs are thoroughly assessed through Core Services prior to entering more intensive community services. Consumers have multiple points

of access to specialty services including self-referral or referral by a core provider, hospital, or crisis service. To support consumers and family members in their having full choice of services and service providers, the Department is exploring ways to make all specialty service contact information readily available in one centralized location.

Core service providers are reimbursed via Medicaid or state dollars or both to provide in clinic and out of clinic services for consumers receiving services from them. While DBHDD still contracts for services funded through state dollars, the Medicaid Rehabilitation Option was opened to additional Medicaid providers in 2007, allowing expansion of Medicaid services in all regions and expanding choice for consumers. The state utilizes contracting requirements and outcome expectations to foster implementation of the desired array of services in the system. Of note, Georgia still operates under a submitted Medicaid State Plan Amendment (SPA) that had far reaching implications for state providers. From 2008 to 2011 essentially, all services, except for ACT, were "unbundled" and each practitioner, based on practice act licensure or educational qualifications, and were grouped into one of five practitioner bands. Rates of reimbursement are based on a complex formula that takes into account productivity, Department of Community Health rates established in the SPA, license, certification or educational qualification, intensity of service and cost of doing business. Moreover, service definitions reflect incremental intervention activities (15 minutes) and define service provider minimum requirements.

Georgia had a subsequent plan approved in 2012 in which some "re-bundling" was allowed. The State Plan was expanded to add several intensive community-based services in order to be responsive to the state's Department of Justice ADA Settlement Agreement. Those services include Community Support Team (community –based, small multi-disciplinary service that operates in the most rural areas of the state), Community Residential Rehabilitation (a rehabilitative residential treatment option), and Intensive Case Management and Case Management (to replace a previous Community Support service). Additionally, the state added some new innovations to the Medicaid State Plan:

1) Peer Support Whole Health and Wellness Coaching
2) Addictive Diseases Peer Support
3) Task-Oriented Rehabilitation (which supports individuals with rehabilitative skills to get and keep work)

Crisis stabilization units, behavioral health crisis centers, mobile crisis services and assertive community treatment assist persons through acute crises while remaining in the community. Although each of the six DBHDD regions has access to psychiatric hospital services for acute inpatient care for adults requiring hospital treatment, utilization of inpatient treatment is closely monitored. Every effort is made to prevent hospitalization through increased reliance on Community Crisis Stabilization Units (CSU), Crisis (walk-in) Service Centers (CSC), Behavioral Health Crisis Centers (CSC, Temporary Observation Unit, and CSU all on the same campus),

and Crisis Respite Services. A network of Crisis Stabilization Units is spread across the state to help consumers in need of intensive interventions including; rapid assessment, stabilization, observation or brief admission. In community settings, the focus of CSU/BHCCs is provision of assessment, stabilization, medication monitoring, nursing services, linkage and referral and other treatments to support the consumer in quickly returning to their own home in the community. In FY11, House Bill 343 was passed pertaining to CSUs. This bill facilitates the entry of new providers into the CSU market in order to expand the spectrum of behavioral health services in the community and allows for the regulation of CSUs through licensure. DBHDD is now the licensing agency.

In addition, there are mobile crisis teams in all six regions. As Georgia enhances community integration options for persons living with a diagnosis of a major mental illness, mobile crisis response services fulfill an important role in stabilizing and supporting persons in crisis while assisting them in choosing the right environment to overcome that crisis. In 2013, DBHDD implemented mobile crisis services by selecting two providers through a competitive bidding process to operate crisis teams serving all 159 counties in the state.

The following services for adults with mental illness are provided statewide through a combination of state, federal and Medicaid funding:

Access and Referral Service

- Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance needs mental health crisis services. The Georgia Crisis and Access Line (GCAL) is a 24 hour/7 day a week resource for Georgians who need either routine, crisis, or inpatient behavioral health services. The system, which includes mobile crisis services in several counties, provides fast and accurate connections with on-the-spot appointment scheduling for services.

Core Services

- **Diagnostic Assessment and Individualized Recovery/Resiliency Planning**
  Consumers have the opportunity to meet with clinicians, physicians, nurses, peer specialists and care managers to receive comprehensive assessment, a recovery plan built to specification and consumer driven and linkage to other community-based services such as housing, employment, whole health planning and support programs. A diagnostic assessment is provided by a physician or advanced practice nurse or physician's assistant trained in psychiatry and includes a bio-psychosocial history, mental status exam, evaluation and assessment of physiological phenomena, psychiatric evaluation, screen for withdrawal if indicated, assessment of appropriateness for service or continuation of service and a disposition.

- **Crisis Intervention**
  Crisis intervention services are available 24 hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in any setting. Services are directed toward the support of an individual who is experiencing an abrupt and substantial change in behavior related to a precipitating situation or a marked increase in personal stress. Crisis services are time-limited and are designed to prevent out of community placement or hospitalization. Interventions are used to de-escalate the situation while facilitating access to a myriad of crisis services when deemed necessary. The individual's behavioral health care advanced directive, if existing, is utilized to help manage the crisis.
- **Psychiatric Treatment**
  Medical evaluation and medication management as well as assessment for appropriateness of treatment and monitoring an individual's status in relation to treatment and medication.

- **Nursing Assessment and Health Services**
  Typically, face to face contact with a licensed nurse who provides nursing assessments to care for physical, nutritional and psychological issues, assess response to medication, consult with consumer about medical, nutritional or health related needs, educate about potential side effects, perform venipuncture, provide assessment, testing and referral for an infectious disease.

- **Medication Administration**
  The act of introducing a drug into the body of another person by any number of routes. Medication administration requires a physician's order and is not the supervision of self-administration of medication.

- **Pharmacy Services**
  Either operate or purchase services to order, package, and distribute prescription medications. Assists consumers in accessing medication assistance programs and performs necessary lab work so that a consumer is not refused service due to inability to pay.

- **Case Management**
  This service consists of providing support, linkage and care coordination considered essential to assist the individual with improving their functioning, gaining access to necessary services and resources, and creating an environment that promotes recovery as identified in his/her individual recovery plan.

- **Psychosocial Rehabilitation- Individual**

Services include individual rehabilitative skills building considered essential in improving an individual's functioning level and learning skills that promote his/her access to necessary services and resources.

- **Individual Counseling**
  A therapeutic intervention where in a qualified clinician employs techniques to assist a person in identifying or resolving personal, vocational, intrapersonal and interpersonal concerns.

- **Family Training/Counseling**
  A therapeutic intervention with identified family populations directed toward the achievement of consumer specified goals with an anticipated outcome of restoration, development, enhancement or maintenance of processing skills, healthy coping mechanisms, adaptive skills and behaviors, interpersonal skills, family roles and relationships, family understanding of mental illness and/or substance related disorders.

- **Group Training/Counseling**
  Services provided in a group format with a skilled clinician or facilitator to address goals and issues the consumer identifies as important to his or her recovery.

Specialty Services

- **Assertive Community Treatment**
  Is a recovery focused, high intensity, community based service for individuals whose past or current response to other community-based intensive behavioral health treatment demonstrated minimal effectiveness, discharged from multiple or extended stays in psychiatric hospitals, frequently seen in emergency rooms, or crisis stabilization units due to SPMI, chronically homeless, and/or released from jails or prisons. A multidisciplinary team provides intensive, integrated and rehabilitative treatment and support within the community, and 24/7 face-to-face services must be available. This service is designed to decrease episodes of homelessness, hospitalizations, incarcerations, emergency room visits, and crisis episodes through comprehensive treatment that promotes community integration.

- **Community Support Team**
  Is an intensive community-based service for individuals in rural areas who cycle in and out of intensive services and have not had their mental health treatment needs met via traditional outpatient services. This service is designed to decrease hospitalizations, incarcerations, emergency room visits, and crisis episodes through community integration. This service includes nursing services, care coordination, individual

counseling, and skill building. Working in partnership with the core provider, this service is available 24/7 with emergency response coverage.

- **Peer Support Services/Forensic Peer Support Services**
  Provide structured activities within a peer support center, inpatient hospital, CSC/Temp Observation, correctional facility, probation reporting center, or mental health treatment court that promote socialization, recovery, wellness, self-advocacy, development of natural supports maintenance of community living skills and successful community reintegration

- **Psychosocial Rehabilitation-Group**
  Is a therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally occurring community settings. Services include group skills building, social problem solving and coping skill development, prevocational skills and recreational opportunities. It is offered twenty-five hours a week, for a maximum of 5 hours per Day.

- **Supported Employment**
  Job development, placement and training for individuals with behavioral health challenges who desire competitive employment and need assistance to locate, choose, obtain, learn and maintain a competitive job in an integrated setting. Services include vocational interest and skills assessment, job search, and maintenance supports that are necessary to perform and retain a particular job.

- **Intensive Case Management**
  This is a recovery focused community approach that assists individuals with complex and high intensity care coordination of service needs with moving between and among services necessary in order to remain in the community. Primary functions of this service include assessment of need, recovery planning, care coordination, access to resources, and monitoring. With a low staff to client ratio and a focus on rehabilitation, interventions are delivered primarily in the community rather than in office settings in order to coordinate needed mental health, physical health, and social services to support the consumer's recovery process.

- **Intensive Residential Services**
  Provides around the clock awake staff to assist consumers to successfully maintain housing stability within the community, continue with their recovery and increase self-sufficiency. A minimum of five hours of skills training is delivered each week to each consumer enrolled.

- **Semi-Independent Residential Services**
  The semi-independent residential service provides on-site staff available to deliver personal support and skills training at least 35 hours per week to each consumer.

- **Independent Residential Services**
  Scheduled residential services to a consumer who requires a low level of residential structure to maintain stable housing. While there must be a written emergency plan that gives consumers access to a residential service specialist 24/7, the service requires a minimum of one face to face encounter per week.

- **Housing Vouchers**
  The Georgia Housing Voucher assists individuals with an SPMI categorization in attaining and maintaining safe and affordable housing and supports their integration into the community. Supported Housing includes integrated, permanent housing with tenancy rights, linked with flexible community-based services that are available to consumers when they need them, but are not mandated as a condition of tenancy. All individuals with financial means are required to contribute a portion of their income towards their living expenses (tenant paid utilities, rent, and initial start-up expenses).

- **Projects for Assistance in Transitioning from Homelessness (PATH)**
  PATH is a SAMHSA grant funded program designed to support the delivery of outreach and case management services to individuals with serious mental illness and those with co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. PATH's homeless outreach teams in Atlanta, Marietta, Columbus, Augusta, Valdosta, and Savannah outreach into the streets and homeless shelters to identify people who are chronically homeless and highly vulnerable to health risks. The teams use assertive engagement strategies to help people access housing and resources needed to end their homeless cycle.

Crisis Services

- **Mobile Crisis**
  This service provides community-based face-to-face crisis response 24 hours a day, seven days a week to individuals in an active state of crisis that threatens their safety. Interventions include a brief, situational assessment; verbal interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural support systems; and referral to alternate services at the appropriate level.

- **Crisis Stabilization Unit**

A residential alternative to inpatient hospitalization, crisis stabilization programs offer psychiatric stabilization and detoxification services through medically monitored services to include psychiatric medical assessment, crisis assessment, support and intervention, medication administration, management and monitoring, brief individual, family or group counseling and medically monitored residential substance detoxification (ASAM level III.7-D.)

- **Behavioral Health Crisis Centers**
  BHCCs provide a community-based setting for adults experiencing a behavioral health crisis to walk in 24/7 and receive triage, evaluation, stabilization, observation, treatment and discharge planning.

- **Crisis Respite Apartments**
  Crisis respite apartments offer a brief period of respite for individuals needing a supportive environment. This service is available for individuals who are transitioning back into the community from a psychiatric inpatient facility, crisis stabilization unit (CSU) or behavioral health crisis center (BHCC)a. Crisis respite apartments include individualized engagement, connection to crisis planning, linkage to treatment, and other community resources necessary for the individual to safely reside in the community.

Inpatient Services

- **State Operated Psychiatric Hospitals**
  DBHDD maintains accredited state operated psychiatric hospitals that provide intensive inpatient services for individuals who present an "imminent danger to self or others".

- **Community Based Inpatient Psychiatric and Substance Detoxification Services**
  This is a short term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance abuse disorder. Georgia is moving away from hospital settings and toward social detoxification, assertive community treatment teams, mobile crisis response teams and crisis stabilization programs.

Substance Use Disorder Services

Substance Use Disorder treatment and recovery support services are contracted through Tier 1, Tier 2, Tier 2+ and specialty providers statewide. By contract, all providers offering the core benefit package must be co-occurring capable. Georgia provides the following service array;

- Outpatient
- Residential
- CSU crisis services

- Detoxification
- Women's Treatment and Recovery Support Services (outpatient, residential and transitional)
- HIV EIS
- Peer Support services
- Addictive Disease Support Services
- C&A Clubhouses
- C&A IRT
- Adult Recovery Centers
- Opioid Maintenance Treatment

Georgia's gender specific and age specific substance use treatment programs use evidence-based practices and fully integrates both mental health and substance use issues in the individualized recovery plan of those individuals who identify substance use as a barrier to recovery. DBHDD has spent several years providing statewide training to ensure competency in assessing and treating both mental illness and substance use disorders. DBHDD emphasizes that addiction specialists receive training in trauma informed care and uses the Trauma Recovery and Empowerment Model (TREM) as well as introducing Seeking Safety specifically geared toward those who have criminal justice involvement and combat induced trauma along with co-occurring disorders. In conjunction with the training needs of providers, the OAD is a board member of The Georgia School of Addiction Studies which helps providers build skills for treating substance use disorders and identifying and treating co-occurring mental illness and addictive diseases. Some scholarships for community mental health providers are available to attend the trainings that are offered.

In May 2017, DBHDD was awarded a State Targeted Response (STR) to the Opioid Crisis Grant by the Substance Abuse and Mental Health Service Administration (SAMHSA). The funding, totaling nearly $11.8 million, is provided for in the 21st Century Cures Act of 2016, and will support DBHDD and other community providers combatting opioid addiction through prevention, treatment, and recovery services. Using a targeted response to the opioid crisis in the state, Georgia's Opioid State Targeted Response project includes project activities to strengthen infrastructure, address gaps in evidence-based practices and services, and enhance the continuum of prevention and recovery-oriented treatment.

Medical and Dental Services

Consumers access medical and dental services through a variety of resources. Those qualifying for Medicaid services generally use Medicaid-approved practitioners while those without means to pay for medical and/or dental services access care through free clinics such as Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Those consumers who need assistance with accessing medical and dental services are linked with appropriate resources,

including, for those who need it, community support and case management practitioners who can remind and assist consumers in meeting their medical or dental appointments.

In order to promote whole health, nurses who are a part of the DBHDD provider network provide behavioral health-centered nursing support and are also enabled through policy to monitor basic whole health elements such as:

- Providing nursing assessments and interventions to observe, monitor and care for the physical, and nutritional problems manifested in the course of the individual's treatment;
- Assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the condition (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.);
- Consulting with the individual's identified family/caregiver/natural supporters about medical, nutritional and other health issues related to the individual's mental health or substance related issues;
- Educating the youth and family/responsible caregiver(s) on medications and potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc.); and
- Providing assessment, testing, and referral for infectious diseases.

Integration of Behavioral Health and Primary Care

Region 2 providers coordinate and partner with several community physicians, local health clinics, local physicians, dental providers and pharmacies as well as a FQHCs. For example, River Edge CSB is in partnership with the FQHC and provides staff to the FQHC which is located at their site. Case Managers assist people with linkage to physical health providers and transportation as needed. As previously mentioned, Advantage BHS is a key collaborator in a jointly initiated project unique to Athens, the Athens Resource Center for Hope. Specifically, Advantage provides outreach and support services within a co-located facility that also housed the Athens Nurses Clinic and Live Forward. Through this partnership they are able to provide collaborative case management and support services that meet the health, financial, and overall stability needs of local homeless individuals and families. In addition, Advantage BHS was awarded a direct SAMHSA grant to expand outreach, HIV education & testing, and substance abuse services to African American Women with or at risk of HIV infection. Central to this grant program, RISE Women's Wellness Program, are formal Memorandums of Agreement that outline referral and colocation activities with Advantage Partners that include Ryan White Specialty Care Clinic, Live Forward, Athens Nurses Clinic, and ACC Jail. The program allows for Advantage to embed licensed clinicians within partner agencies for the purpose of integrating primary health and behavioral health services with a "warm hand-off" model. Additionally, Advantage partners with these organizations to conduct community education and HIV testing

events. These partnerships have helped to expand Advantage's client base and bolster outreach activities to those in need.

Region 1 providers partner with medical providers in their service area. Avita CSB partners with Georgia Highlands Medical Services, Medlink, Good News at Noon and Clinic, Good Shepherd Medical Services and First Baptist Church (medicines for homeless individuals). Cobb CSB partners with the Lifeline Project for HIV, and HEP C testing and treatment. In Region 3 Grady Behavioral Health and Mercy Care's primary care and physical health have co-located services. In Region 4, the Field Office Regional Services Administrator has been working with a local FQHC, Albany Area Primary Health to partner on grant opportunities to test primary care/behavioral health models. In Region 6, Middle Flint CSB is working on a partnership with a local Healthcare agency; New Horizons CSB is a participant in the Better Life Integrated Behavioral Health/Primary care Program; and, Pathways CSB is a partner with the Good Samaritan Clinic, Your Town Health, and the Rapha Clinic. In Region 5, Gateway CSB partners with community health providers such as McKinney Community Health and Two Rivers Health. In addition, they have MOUs with Coastal Community Health, Diversity Health Center and Cutis Cooper Center. In addition, in Region 5, the CSB of Middle Georgia partners with FQHCs and health clinics in their area as well as the local county health departments on referrals, access to primary care physicians and medications. CSDBMG has licensed staff and paraprofessional staff who provide services in several pediatricians' offices on a regular basis as well. Healthy Start is a collaborative partner whose board CSBMG is on and have developed programming around the needs of the individuals they serve.

Suicide Prevention

In FY 2007, the General Assembly approved legislation to create and fund the Suicide Prevention Program to be located in the Department of Human Resources, Division of Public Health. In FY2007, 2008 and 2009 the Suicide Prevention Program was managed by the Division of Public Health. During these years, the Division of MHDDAD in the Georgia Department of Human Resources participated in the Suicide Prevention Coalition of Georgia (SPCGA), along with the Suicide Prevention Program, to plan for the implementation of key suicide prevention activities. In FY 2010, with the creation of the new Department of Behavioral Health and Developmental Disabilities, the Georgia Suicide Prevention Program moved into DBHDD with revised enabling state legislation. The Suicide Prevention Program is currently housed within the DBH Office of Prevention Services. Because of this history the Suicide Program has both a public health and a behavioral health approach.

The current DBHDD suicide prevention team is led by the Director and Assistant Director of the Office of Prevention and staffed with the state Suicide Prevention Program Coordinator, Suicide Prevention Specialist, and Garrett Lee Smith Youth Suicide Prevention Grant Director. The Suicide Prevention Program developed and provides technical assistance related to DBHDD

Policy 01-118, Suicide Prevention, Screening, Brief Intervention and Monitoring that was implemented in all Tier 1 and Tier 2+ comprehensive community provider organizations July 1, 2016. This policy provides that all consumers who present for services are screened for past and/or present suicide ideation and behavior; all consumers who screen positive are provided a jointly developed safety plan, and monitored for safety. Further, for those at risk of suicide a Suicide Risk Formulation is developed and guides the suicide specific care set forth in the care management plan. All tools used in this suicide care are evidence based and embedded in the electronic record of the provider organization. All staff are trained use the evidence-based tools before use and all provider staff are trained in suicide gatekeeper training during the on-boarding process. In addition to supporting this policy implementation, the suicide prevention team works in the community to provide education, resource information and support for loss survivor. A summary of the work of the Suicide Prevention Program is included in the Environmental Factors and Plan section.

Other System Integration

The DBHDD is heavily involved in many initiatives that coordinate mental health services within a broader system. The Department has developed memoranda of understanding and other types of partnerships with organizations including The Division of Aging Services, the Department of Human Services, the Department of Community Health, the Department of Community Affairs, the Department of Public Health, the Georgia Vocational Rehabilitation Agency, the Department of Corrections, the Department of Community Supervision, and other governmental agencies.

DBHDD and the Division of Aging Services (DAS) partnered with the Carter Center Mental Health Forum and the Centers for Disease Control and Prevention to offer a national conference on Effective Programs to Treat Depression in Older Adults: Implementation Strategies for Community Agencies – From Research to Practice. The Georgia Peer Support Institute conducted a pilot training with Certified Peer Specialists on Peer Support and whole health initiatives for older adults. DAS is a very active participant on the BHPAC and are very active partners in planning for the needs of older adults living with mental illnesses. In July 2014, DBHDD and DAS entered into an agreement with the Fuqua Center for Late-Life Depression, Emory University to strengthen Georgia's system of care for the growing older adult population with severe and persistent mental illnesses. In FY18 this agreement has been extended to include The Carter Center. A staff member from DBHDD and DAS have time committed to this work. The Georgia Coalition on Aging and Behavioral Health (GCOABH) whose membership consists of staff from DBHDD, DAS, DCH, DPH, CDC, and numerous other organizations and people interested in the needs of this population including family members and older adults, has led efforts to cross train the aging network and the public behavioral health system regarding both systems of care and how to access services. Extensive training regarding recovery in older adults, decision making capacity in persons with mental illness and dementia, and care

coordination across systems has taken place, and efforts are also underway to improve the direct care of this vulnerable population through local partnerships between aging services providers and public behavioral health service providers.

Housing and employment are two priorities for persons with mental illness that have benefited from collaboration between the mental health agency and other parts of the service system. On the employment front, the Georgia Vocational Rehabilitation Agency and DBHDD entered into a Memorandum of Understanding (MOU) to coordinate the delivery of behavioral health and vocational rehabilitation services in an effort to increase employment outcomes for individuals with serious and persistent mental illness. Throughout this collaborative work both agencies have continued to provide cross training to staff working respectively with the dually enrolled population to promote understanding on behalf of both agency's staff and ensure the vitality of the services being rendered to dually enrolled individuals. These training opportunities have allowed DBHDD to increase access to GVRA services statewide via this partnership. Both partnering agencies will continue cross-training this fall; while focusing on a statewide refresh for new and existing staff.

Regarding housing, DBHDD and the Department of Community Affairs (DCA) have a Memorandum of Understanding in which joint planning; funding requests and requests for procurements are designed to develop supportive housing opportunities and prioritize access to rental assistance programs for consumers living with mental illnesses. In FY08, the Department of Community Affairs (DCA) and DBHDD entered into a partnership to expand the housing resources for homeless individuals and those with mental health disabilities. The two Departments have been working cooperatively to establish independent, permanent supported housing programs and assist individuals in obtaining and maintaining safe, affordable housing. DCA provides many financing programs to develop housing and DBHDD provides the residential supports needed to assist people in staying in the communities of choice. DBHDD continues to strengthen partnerships that can increase the availability of permanent supported housing for those with serious and persistent mental illness who are homeless. In FY 2017, DBHDD and DCA expanded their MOU and created the Director of Supported Housing position to cooperatively advance the collective housing efforts of both agencies. In March of 2017, the Office of Adult Mental Health, created the Supported Housing Unit, under the direction of the Supported Housing Director, this unit will move forth the goals of supporting providers of both housing and residential services as well as meeting and sustaining the supported housing requirements of the Settlement Agreement Extension. This includes, increasing access to independent, permanent supported housing for our target population, maximizing state resources for supported housing for our target population, operationalizing a statewide unified referral process for supported housing, and continuing the work of oversight of the statewide supported housing need and choice survey. This unit will work in collaboration with the DBHDD and DCA regional field offices, community BH providers, hospitals, state and local agencies and law

enforcement to support comprehensive implementation of strategies that will promote supported housing access statewide.

The State of Georgia was awarded $14.4 Million from HUD to provide long-term project-based rental assistance to persons with disabilities. The HUD 811 PRA grant provides units of housing that are attached to new and existing tax-credit apartment developments around the state. The State of Georgia, through the Department of Community Affairs (DCA), has seized upon this exciting opportunity to expand its inventory of housing resources through the Section 811 PRA Demonstration Program in furtherance of its commitment to provide integrated housing opportunities with support services to extremely low income persons with disabilities and their families. The State of Georgia also received a HUD waiver to prioritize those meeting the DBHDD DOJ target population criteria for a preference Housing Choice Voucher (HCV). Through these strategic efforts, DBHDD and DCA are expanding and utilizing funding diversity and leveraging thus increasing and stabilizing housing opportunities for individuals with SPMI.

The Division of Behavioral Health continues to sustain and expand relationships with the state Department of Veterans Services, the Department of Veteran Affairs, and Veterans Administration Medical Centers due as a result of to the past award of a SAMHSA Jail Diversion and Trauma Recovery – Priority to Veterans grant. An example of this collaboration is DBHDD's training of VA CPSs on the base curriculum, as well as Whole Health, using the Whole Health Action Management training. Also, as previously mentioned the BHCC established an initiative in 2013 whereby the Transition Workgroup was developed to address the needs of persons transitioning from the correctional/justice system into the community. The Workgroup is co-chaired by the DBHDD Director of Adult Mental Health and the Department of Community Supervision Reentry Director. Early outcomes are fostering inter-agency partnerships to address barriers and infrastructure challenges for persons in the criminal justice system. DBHDD is involved in the Georgia Prison Reentry Initiative (GPRI). This collaboration brings partnering agencies together to address issues of service access and effective community transition for persons with a mental illness who are returning from the correctional system.

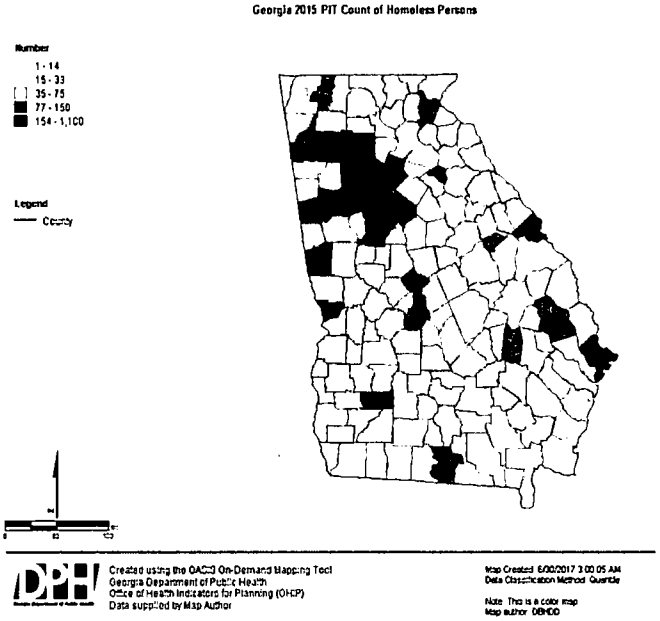
Criterion IV: Targeted Services to Rural, Homeless, Older Adults and Special Populations

Outreach to Homeless

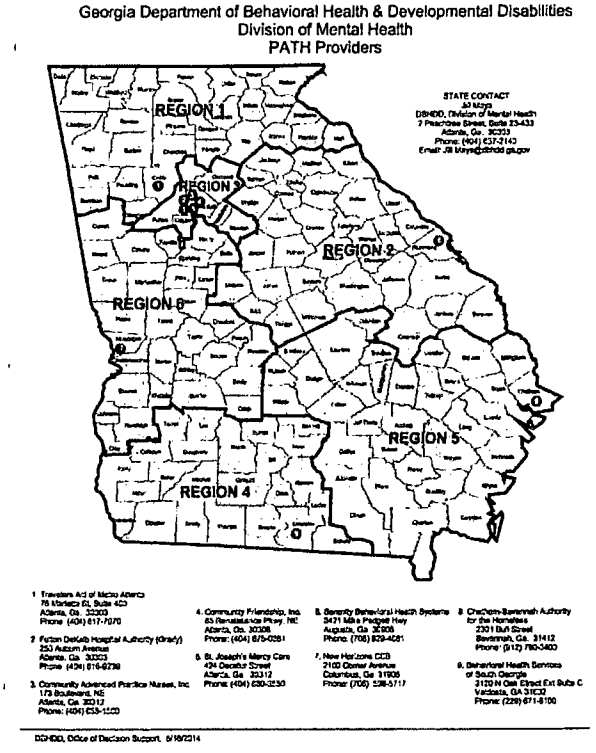
Substance Abuse and Mental Health Services Administration (SAMHSA) indicates 20% to 25% of the homeless population in the United States suffers from some form of severe mental illness. In 2018, according to the HUD Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations report of data from the January 22, 2018 Point-in -Time count, on that night in Georgia there were as many as 1,875 (24%) homeless adults with severe mental illness, and as many as 1,080 chronically homelessness persons. A comparison of the 2015 PIT Count of Homeless Persons map (Image 1) and the PATH Local Area Providers map (Image 2)

below, demonstrates that current PATH teams are located in areas of the state with the greatest number of individuals who experience homelessness with serious mental illnesses or co-occurring substance use disorders.

2015 PIT Count of Homeless Persons (Image 1)



PATH Local Area Providers by DBHDD Region (Image 2)



It is the overall goal of the Projects to Assist in Transition from Homelessness (PATH) program to effectively and efficiently reduce homelessness for individuals with mental illness who do not access traditional mental health services on their own. The primary functions of PATH program are to identify, engage, and link homeless individuals to mainstream mental health services, housing resources, and other needed community resources. The strategy of linking engaged individuals to mainstream providers rather than establishing a parallel service system for homeless consumers conserves Georgia's scarce mental health resources. The success of the transition of individuals from PATH programs to mainstream services requires a good relationship between PATH funded agencies and mainstream agencies. PATH funding supports outreach services that goes into communities to identify and engage "literally" homeless individuals who are unable or unwilling to access mainstream mental health services on their own. Georgia uses hired Consumer Practitioners with homeless experiences to share their personal story of recovery to help establish client rapport and a client commitment to change. A

large percentage of those receiving PATH services are successfully transitioned into mainstream service systems where they receive the resources necessary to end their homelessness.

DBHDD embraces the desired outcome of PATH programs to end chronic homelessness. In SFY16, a total of 3,029 homeless adults received benefits from PATH funded services, which are located in metro-Atlanta, Savannah, Columbus, Valdosta, and Augusta. Of those enrolled, 1,433 adults (88%) with serious mental illness or co-occurring disorders received ongoing community mental health services. Georgia uses outcome measures to identify the effectiveness of PATH services on ending homelessness by the percentage of those discharged from PATH that access housing and link to mainstream behavioral health services. Of the total number of individuals discharged from PATH services in FY 2015 (n=762), 23% (n=172) remained homeless but linked to mainstream behavioral health services, and 77% (n=590) accessed housing **AND** linked to mainstream behavioral health services.

It is Georgia's vision for FY16 through FY21 to increase PATH effectiveness at ending homelessness for adults with mental illness. PATH Teams use the vulnerability index survey developed by Common Ground Institute, to identify those most at risk of dying on the street within one year to mobilize action to access housing and services. PATH Teams are encouraged to directly link those chronically homeless who are identified as most "at risk" to ACT Teams. In addition to the state ACT Coordinator presenting as a resource at PATH Coalition meetings, PATH and ACT providers attend and annual combined provider Coalition meetings to build and strengthen the referral bridge between PATH and ACT. Georgia's PATH Program attributes its effectiveness to active state monitoring and provision of TA/training, the development of PATH Provider Quality Improvement Plans, and prioritizing the use of Outreach and Case Management services.

The PATH Training Summit took place June 18 – 19, 2019 at James Rainwater Conference Center in Valdosta, GA. This year's theme was: "Housing Beyond the Key" Ending Homelessness for Georgians with Mental Illnesses! This conference was presented by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) Office of Adult Mental Health and funded in part through SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) grant.

The 2019 PATH Training Summit focused on effective strategies and resources for service delivery, including 1) Homeless Management Information System (HMIS) 2) HUD Coordinated Entry, 3) Deeper understanding of mental illness and its implications for homelessness, 4) spirituality and recovery 5) Homeless Service Project, and 6) PATH teams in review. Speakers will include subject matter experts. Providers from all across the state came to Valdosta, GA this June to learn about what is working, shared successes, and to meet others who are diligently

working to end homelessness in Georgia. All staff paid using PATH funds were required to attend.
Attendees received the following:

- Reviewed HMIS and PATH data requirements.
- Learned about best practices from the field to assure that individuals with serious mental illness have easy access to supported housing and community behavioral health services.
- Participated in a learning environment where providers can share their energy and experience in driving down homelessness in their community and learn from the experts across the service continuum who are making it happen.
- Identified appropriate resources and potential collaborations in their communities to assist people experiencing homelessness.
- Identified how having a spiritual connection helps build recovery and hope.
- Had fun learning in a relaxed, interactive environment!

According to DBHDD data for 2016, 5,948 homeless persons accessed mental health services (5,851 adults; 97 children). Georgia is committed to ending homelessness by implementing strategies that increase access to permanent housing and mainstream services for chronically homeless individuals and families with severe mental illness.

In partnership with the Department of Community Affairs (DCA), DBHDD works with core providers to identify target populations and areas of the state in need of Shelter plus Care housing. DBHDD also helps to establish supportive housing using Housing Choice and 811 Program vouchers and attaching mental health services and supports for those individuals who choose them. This has been an effective collaboration that helps consumers who are homeless to access safe, decent and affordable housing and receive community-based recovery services.

The costs of homelessness are great for individuals as well as for states and communities. Estimates of up to $4 billion is spent annually on homelessness by local and state governments, health care providers, correctional facilities, emergency shelters, and other providers of services to people who are homeless. Social Security Administration oversees Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefit programs for people with physical and/or mental disabilities. For people with disabilities who are homeless, the immediate gains of SSI and SSDI are clear; a steady income and health insurance. Despite the benefits to individuals and communities, an estimated two-thirds of people who are chronically homeless and have mental illness do not receive SSA disability benefits. Many likely would be eligible for SSA benefits; however, in Georgia only 20 percent of those who apply are approved upon initial application.

DBHDD supported a SOAR Demonstration Project between 2007-2011 to demonstrate increased access to SSI/SSDI for mentally ill adults experiencing homelessness; and to teach others how to

use SOAR techniques to dramatically expedite the application process and reduce the disability determination period. In 2013, DBHDD entered into a formal agreement with the Department of Community Health (DCH) to hire six (6) Medicaid Eligibility Specialists (MES) to actively assist individuals coming out of state hospitals with accessing Medicaid/Medicare. As of 2016, there are now 9 full time MESs. All MESs have consistently maintained In FY15, 220 applications were approval at rates of 85-89%. DBHDD continues to provide SOAR training using SAMHSA's curriculum to contracted providers throughout the state. Training dates for 2019, so far, were January 15th and 16th, February 11th and 12th, March 28th and 29th, April 11th and 12th, May 15th and 16th, June 4th and 5th, July 25th and 26th, and August 15th and 16th, 2019.

DBHDD Field Offices and providers are engaged in local communities with planning for and provision of services to homeless individuals. Below are some highlights of the regional activities.

The Region 1 Field Office staff have hosted Regional Community Collaboratives and Crisis Continuum Meetings and participated in other provider and stakeholder meetings/coalitions to address the needs of homeless individuals. These have included meetings with: Unify North Georgia; Highland Rivers Health (CSB) with Floyd Care Transition Team, The William Davies Homeless Shelter, and the Salvation Army Shelter; Avita CSB with Action Ministries, Joe's Place, Set Free Ministries, Baptist Mission in Gainesville, Gainesville Connection (free bus passes for homeless to get to appointments), Chattahoochee Baptist Association, and Salvation Army Shelter Gainesville; and, the Cobb CSB with MUST Ministries for Homeless. In addition, all ACT Teams in the region have relationships and conduct outreach to shelters throughout the region.

The Region 2 Field Office staff have hosted Regional Community Collaboratives and Crisis Continuum Meetings and participated in other provider and stakeholder meetings, such as the COCs in their region. In addition, the providers screen individuals for homelessness and make housing available as appropriate in Shelter Plus Care or the GHVP. One of the providers also has a formal partnership with a day service center for homeless individuals. The PATH team provides outreach and is a good resource for homeless shelters in one of the provider areas. Another provider is a collaborator with the Athens Resource Center for Hope. This Center includes formal partnerships among Advantage Behavioral Health Systems, Athens Nurses Clinic, Live Forward (Formerly AIDS Athens), Athens Area Homeless Shelter, and Little Angels Daycare. Specifically, Advantage BHS provides outreach and support services within a co-located facility that also houses the Athens Nurses Clinic and Live Forward. Advantage BHS created the Advantage Homeless Day Service Center (HDSC) which serves as the entry point for homeless individuals into our local homeless continuum of care. The Center provides laundry & shower facilities, facilitates support groups, serves as a mailing address, offers case management,

advocacy, linkage to care, and housing assistance to individuals and families living in a homeless situation. The HDSC is the central component to the Athens Resource Center and provides coordinated assessment to individuals coming off of the street in order to assist them in accessing the support the need in overcoming barriers to housing stability. Advantage BHS also participates in the Northeast Georgia Homeless & Poverty Coalition which is the local networking and planning body that determines local needs and prioritizes services geared toward alleviating homelessness within the Athens-Clarke County Metro Area.

The Region 3 Field Office staff have hosted Regional Community Collaboratives and Crisis Continuum Meetings and participate in other provider and stakeholder partnerships such as work with the Atlanta Continuum of Care (COC), the agency focused on gaining housing for homeless people, to identify and link homeless individuals, including women and children, to behavioral health providers. The staff also respond to calls from women shelters as well as domestic violence shelters asking for assistance in locating housing and Behavioral Health providers. If the individual meets criteria, the staff link them with one of the state funded providers to complete the Georgia Housing Voucher Program (GHVP) application. The PATH teams have also placed women with children into the GHVP.

The Region 4 Field Office staff facilitates 5 Regional Community Collaboratives quarterly. These meetings are attended by members of the Homeless Coalitions and their partners, such as NAMI, law enforcement, etc. They are also well attended by local hospitals who have homeless individuals in and out of their emergency rooms. In addition, the Regional Transition Coordinator participates in Homeless Coalition meetings throughout the region and attends local Department of Community Affairs meetings (state housing authority).

In Region 5, the Regional Community Collaboratives (RCCs) address homeless issues and concerns. RCCs include membership from the Salvation Army, Union Mission, Homeless Authority, United Way, Family Connection, shelters and faith-based homeless service providers to name a few. A particular area of interest for the RCCs is housing. In the Unison CSB area, Coffee and Ware County both have committees that address the homeless population. A Community Development Block Grant is being sought by the County Commissioners to build an Emergency Homeless Shelter with wrap around agencies to provide services. The FQHC is a partner in Coffee County and work with Unison on the needs of referred individuals.

In the Gateway CSB service area, Gateway works with a shelter for abused women and offers a peer program on site at the Grace House, which is a homeless shelter for 90 men. In addition, the agency participates in a homeless coalition which has community collaborators from Law enforcement, other providers, government officials and child welfare. Gateway also participates in a Coordinated Entry Planning Meeting with DCA, Shelter Plus, Gateway BHS (Liberty), Homeless Prevention, United Way, Veterans Administration (Hinesville), Diversity Health

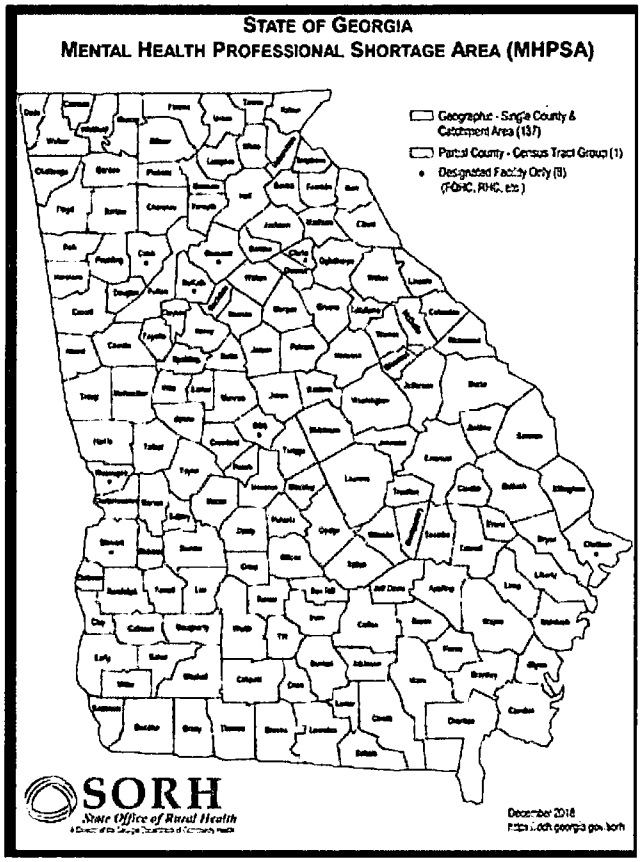
Center, Family Connection (Liberty/Long/Bryan) GA Dept. of Labor, Fraser Center, Department of Juvenile Justice (Liberty County), The Liberty County Homeless Coalition, and the Liberty County Re-Entry Coalition, Inc. Gateway also works with the Savannah-Chatman Homeless Authority, Glynn County Homeless Authority and FQHCs in their service area. The Community Service Board of Middle Georgia works with a homeless provider to solicit resources needed and has specifically supported food drives within the community. CSBMG is an active participant in the GA Housing Voucher Program and Housing First as well. CSBMG also offers Shelter Plus Care through funding received. The Pineland CSB has Shelter Plus Care, Ga Housing Voucher, and Bridge Funding. Currently they have 3 households with women and their children in their Shelter Plus Care Services. From 5/1/16 to 4/30/17 Shelter Plus Care served 53 adults and 14 children totaling 67 individuals. Pineland currently has 22 units in production housing 25 adults and 6 children (22 individuals and 3 families). Pineland 's Community Collaborative includes the Housing Authority Directors and the Director of a new local homeless shelter.

The Region 6 staff have hosted Regional Community Collaboratives and Crisis Continuum Meetings and participate in various other coalitions focused on the needs of homeless individuals and provide services that support the needs of homeless individuals. American Work participates in the GHVP and has an ACT Team that provides linkage for housing through case management. The agency also participates in several community collaboratives: Stewart Community home, Home for Good Committee, Homeless Network Collaboration and Mental Health and Veterans Courts. McIntosh Trail CSB participates in the GHVP, provides ACT and Case Management and linkage for housing through case management. This agency also participates in Mental Health Court. Middle Flint CSB and New Horizons CSB have Shelter Plus Care and the GHVP as well as Intensive Case Management services which provide linkage for housing. Pathways CSB has Shelter Plus Care and participates in the GHVP. They also provide ACT and case management services to provide linkage for housing resources. They reach out to local shelters and participate in the Homeless Coalition and Aging Collaborative. Phoenix Center has partnerships with the local Housing Authority, the Salvation Army Shelter and Safe House and participates in the GHVP as well as provides case management through Community Support Teams. In addition, they partner with: Family Promise of Greater Houston County, MH Accountability Court of Houston County, and Community Action Agencies.

Rural Area Services

DBHDD contracts with providers to cover all areas of the state. The Georgia Crisis and Access Line (GCAL) provides people seeking behavioral health services with information and access to comprehensive outpatient and crisis services throughout the state. A challenge to service provision in some areas of the state is a behavioral health professional workforce shortage. In many counties, there are few to no licensed behavioral health practitioners, and DBHDD is often in competition with other agencies and organizations for these critical staff. Georgia's Mental

Health Professional Shortage Areas continue to expand where now 150 of 159 counties are MHPSAs, as per the figure below:



One example of a service challenge is ACT. ACT is currently available in each region of the state; however, it is difficult to support an ACT team in rural areas due to dispersed populations and professional workforce shortages. DBHDD worked with the State Medicaid Authority to add a rural modifier to ACT to promote statewide expansion of ACT-type services. Therefore, DBHDD offers Community Support Teams (CST) to individuals living in rural areas. CST is led by a licensed clinician, includes a Registered Nurse, case manager, and Certified Peer Specialist.

Georgia continues to heavily invest in its Certified Peer Specialist workforce to promote recovery-based support capacity. In order to promote access, DBHDD has expanded CPS certification courses from metro Atlanta to the southern part of the state to promote rural workforce expansion. In 2019, DBHDD completed a database for all CPSs in order to map their locations and begin working toward geo-mapping to understand the capacity in rural areas. Additionally, the majority of peer wellness centers are located in rural communities and there are peer warm lines that operate 24/7. This is in addition to the GCAL which also operates 24/7 providing access to clinicians. Peer specialists continue to infuse recovery into the service system and into the lives of individuals served as well as to provide much-needed goal-advancement during gaps between visits with licensed practitioners.

Another challenge is transportation to services. In some parts of Georgia, transportation is a serious problem. Medicaid enrolled individuals are able to utilize Medicaid transportation systems for travel to services; however, transportation services remain a challenge in more rural areas. Because many individuals with behavioral health needs lack access to natural supports to assist them in traveling to services many miles away from their homes, funding for transportation to Settlement services was approved by State legislators as a part of the original Department of Justice ADA Settlement Agreement. DBHDD has entered into a contract with the Department of Human Services to provide state supported transportation for individuals receiving the intensive community adult mental health services including: ACT, CST, CSU, ICM, CM, and Supported Employment services.

The Medicaid State Plan approved in May 2017 includes a new Consultation code approval to allow Tier I and Tier II BH Providers to bill when they engage with practitioners external to the system. The goal of the service is to allow these providers to access external and remote medical professionals to 1) promote health integration and 2) to access remote medical specialists to support and or refine diagnosis, prescribing, and treatment. This will assist rural providers in accessing specialists in other communities to support the individuals in those rural areas.

Telemedicine continues to be an emerging avenue for dealing with the shortage of physicians and other practitioners in rural areas and Georgia is exploring additional ways to promote the effective use of telemedicine into the system of care.

Georgia maintains and is growing the following approaches to telemedicine:

- The state continues to use teleconferencing for clinical supervision and discharge planning purposes in its state facilities;
- Teleconferencing can be utilized for the provision of Community Transition Planning, a transition support services which provides support services to individuals in the last few days of a facility admission, promoting post-inpatient community engagement;
- Georgia's Medicaid State Plan continues multiple service definitions which allow telemedicine (traditional services such as Physician Assessment, Diagnostic Assessment). In 2017, telemedicine capacity was expanded to allow non-English speaking individuals to access a same-language speaking practitioner via telemedicine for any Core and most Specialty services.
- There are over 60 DBHDD provider sites that are participating in the Global Partnership for TeleHealth [http://www.gatelehealth.org/about/partnerslocations/]. All state hospitals are telemedicine enabled.
- Both of the DBHDD's Mobile Crisis vendors have telemedicine capacity.
- Approximately a dozen more private and non-profit affiliated vendors are telemedicine enabled.

- DBHDD provided telemedicine capacity grants to XX # of youth mental health providers for youth behavioral health services and 12 Community Service Boards specific to ASD services expansion.

DBHDD continues its telemedicine interactions to promote quality stabilization, treatment, and transition. The DBHDD policy focuses on three key interaction areas:

- Telemedicine between DBHDD facilities and/or offices
- Telemedicine between DBHDD facilities and other medical facilities, for example:
  - ✓ Consultation with Emergency Departments or Crisis Stabilization Programs regarding referral for admission
  - ✓ Medical care consultation from specialists
- Telemedicine between DBHDD facilities and community entities, for example:
  - ✓ Discharge planning with Community Providers of behavioral health or developmental disabilities services
  - ✓ Sheriff Departments
  - ✓ Civil commitment hearings

Older Adults

In Georgia, the older adult population (age 60+) is projected to grow by more than 1 million people, totaling more than 2.5 million in 2030 (Administration on Aging, 2012). The National Institute of Mental Health estimates 19.8% of older adults in the U.S. have a diagnosable mental disorder during a 1-year period, which can create functional impairment, poorer health outcomes, and even increased rates of mortality (U.S. Department of Health and Human Services, 1999). In Georgia, this translates to 294,000 older adults per one-year period with a diagnosable mental disorder.

The Mental Health needs of older persons have received increased attention through the state's participation in 1) the National Governors Association Policy Academy - **Rebalancing Long-Term Care Systems Toward Quality Community Living and Healthy Aging,** and 2) the Centers for Disease Control Prevention Research Center's (CDC) Healthy Aging Network. The DBHDD Community MH Services Director and the Director of the Division of Aging Services (DAS) both served as members of the state team to develop plans to improve access to all services needed by older adults in Georgia and helped establish Georgia's network of Aging and Disability Resource Connections to serve as an entry way to long-term care support services for individuals with disabilities and the elderly. The goal for mental health improvement is to enhance the coordination and delivery of mental health services for older adults as it relates to the screening, referral, and treatment of mood disorders, primarily depression, as well as anxiety and co-occurring disorders. This will include the development of treatment protocols, reliance on evidenced based programs, wellness and improved collaboration between state services and primary care and/or family practice physicians.

DBHDD participates in the Georgia Coalition on Older Adults and Behavioral Health (GCOABH). In 2014, DBHDD partnered with DAS, the Fuqua Center for Late Life Depression, and Highland Rivers Health at the Rosalyn Carter Georgia Mental Health Forum in advancing actions regarding effective programs and policies to address behavioral health issues in older adults. Additionally, one of the members on the Behavioral Health Planning and Advisory Council works for DAS in order to ensure that older adult issues are well represented.

The Georgia Mental Health Consumer Network, the Fuqua Center for Late Life Depression, the DAS, and DBHDD partnered to develop a curriculum and trained Peer Specialists to work with older adults with mental illness on whole-health goals and activities. A demonstration training for Certified Peer Specialists in working with older adults on whole- health activities was conducted as a result of the TTI SAMHSA grant. Training was provided in to increase the number of Peer Specialists who can support and provide services to older adults. This was accomplished by partnering with primary care settings that serve a significant older adult population. Other significant collaborations have included elder abuse prevention efforts, suicide prevention, and the use of chronic disease self-management programs to enable individuals to remain as independent as possible in the community. State training related to "Mental Health First Aid" has been completed for DAS adult protective service workers and long-term care ombudsman.

The Department of Community Health (DCH) utilizes a network of DBHDD behavioral health providers to deliver mental health services to nursing facility applicants and residents authorized through the Pre-Admission Screening and Resident Review (PASRR) Program. This brought DBHDD providers into the geriatric services market and, thus, encouraged development of expertise and capacity. Many of these same providers also deliver various home and community-based services to individuals in the Medicaid Community Care Services Program who otherwise need institutional care in a nursing facility and who qualify or potentially qualify for Medicaid. DBHDD administers the L2 for PASRR through its ASO vendor and closely partners in the timely access to behavioral health nursing facility services with the DCH.

Currently, DBHDD has a Memorandum of Understanding with The Carter Center and the Fuqua Center for Late-Life Depression/Department of Psychiatry and Behavioral Sciences of Emory University to facilitate ongoing cross training of staff at DBHDD, its contracted behavioral health treatment providers, and DAS network of aging services providers in order to strengthen the existing system of care that serves older adults who have a mental illness or co-occurring disorder. Work guided by the MOU includes identification of unmet needs of this population and the development of applicable processes aimed at improving the state's capacity to care for Older Adults with Mental Illness. Initiatives include training on Evidenced-Based Practices (EBPs), development of partnerships through involvement in Coalitions and other collaborative

efforts, opportunities for gaining understanding on services available and how they are accessed as well as Policy development to address barriers that impact access to care. To date cross-training events have included:

Date	Event	Content
January 2015	GA Behavioral Health Planning & Advisory Council	• Introduction To DBHDD/DAS/Fuqua Partnership for Building A System of Care for Serving Older Adults with Mental Illness • Overview of the ARDC
June 2015	ADRC Healthy Communities Conference	*Building Capacity to Care for Older Adults with Mental Illness* • Welcome and Brief Overview of Collaborative Work • Introduction of Concept of Recovery and Older Adults with Mental Illness • Overview of Public Mental Health System Services and Access to Care • Case Studies Including Group Discussion on Challenges and Practical Ways to Work Together to Take Care of Older Adult Clients
July 2015	GA Association of Community Care Providers (GACCP) Conference	*Building Capacity to Care for Older Adults with Mental Illness* • Overview of Services Available to Older Adults: GA Crisis & Access Line (GCAL); Mobile Crisis; Statewide Core & Specialty MH Services
August 2015	Georgia Gerontology Society (GGS) Conference	*Building Capacity to Care for Older Adults with Mental Illness- 2 PARTS* PART I (One Hour) •Introduction of Concept of Recovery and Older Adults with Mental Illness •Overview of Public Mental Health System Services and Access to Care PART II (One Hour)

		•Case Studies including Group Discussion on Challenges and Practical Ways to Work Together to take Care of Clients
September 2015	ARC Atlanta Area Agency on Aging	*Building a Behavioral Health Team That Best Serves the Older Adult*
October 2015	DBHDD 2015 Behavioral Health Symposium	*Building Capacity to Care for Older Adults with Mental Illness* • Concept of Recovery in Older Adults (Kimberly Williams MHA-NYC) • Dementia 101 (Monica Parker, MD) • How to assess and appropriate services for people with dementia and SPMI (Larry Tune, MD) • Decision-Making Capacity: Legal and Clinical Considerations/Tool Kit (Dr. Jason Shillerstrom) • Overview: Evidence-Based Treatment for Older Adults (TBD) • Case Studies: Treatment and Service Options for Older Adults within the Public BH System
February 2016	NCOA Center for Health Aging webinar	*Achieving Collaboration Between Mental Health and Aging Services through Coalition Building*
June 2016	ADRC Healthy Aging Conference	*Strengthening the System of Care through Collaboration*
April – December 2016	• April—Three Rivers AAA & DBHDD Region 6 Providers • May—Heart of Georgia AAA & DBHDD Region 5 Providers • June—Atlanta Region AAA & DBHDD Region 3 & 6 Providers • Legacy Link AAA & DBHDD Region 1 Providers	*Regional Strengthening the System of Care through Collaboration Cross-training Workshops*

	◦ December--SOWEGA AAA, Adult Protective Services & DBHDD Region 4 Providers ◦ December--CSRA AAA, APS, & DBHDD Region 2 Providers	
October 2016	DBHDD 2016 Behavioral Health Symposium	*(1) Care Coordination is the Key to Success-Knowing Your Aging Services Partners* *(2) Billing Medicare in a Fee-For-Service Environment.* Focus was given on helping BH providers who serve Georgia's growing population of older adults with Serious and Persistent Mental Illness work with Aging Services' providers of home and community based long-term care to understand payment mechanisms for services needed by older adults. A representative from the Center for Medicaid and Medicare provided an overview of Medicare billable services relevant to behavioral health providers. The session also provided an overview of home and community support services provided by Georgia's Long-Term Care Medicaid Waivers: Community Care Services Program (CCSP) and SOURCE, as well as services funded through the Older American's Act.
June 2017	2017 ADRC Healthy Aging Summit in Augusta	*Collaboration between Area Agencies on Aging and Behavioral Health Providers: A Recipe for Success in Serving Complex Cases*
June 2017	Evergreen Stone Mountain Conference Center	*Leadership Summit*-- updated AAA and CSB leaders about the work done to date to strengthen Georgia's capacity to care for older adults who have a mental illness, showcasing innovation partnerships

		that have taken place between several AAAs and CSBs around the state in regions where training forums have occurred, as well as to share and discuss data prepared by DBHDD relevant to service provision by CSBs to older adults
Scheduled: October 2017	DBHDD 2017 Behavioral Health Symposium	• *Evaluation of Dementia in People Who Have Severe and Persistent Mental Illness* • *Collaboration between Area Agencies on Aging and Behavioral Health Providers: A Recipe for Success*

Veterans Initiatives

Since September 2008, DBHDD's Division of Mental Health has been working diligently on creating initiatives that will have an impact on our Veterans. As one of the largest states in the U.S. with an expanding population of Veterans, Georgia is developing an infrastructure of competence in serving the needs of returning veterans. According to the US Census Bureau Quick Facts, there were 646,350 Veterans in Georgia between 2013-2017. With the large number of Veterans in the state, there is a need to address issues facing these Veterans and their families, and also a need to train interfacing agencies on how to be effective with this population.

In FY18 GA PATH Teams served 123 known homeless veterans, 4.8% of individuals served by the program. All PATH providers must demonstrate work experience and background in working with veterans. Mental Health America and the Department of Veterans Affairs estimate that 25-40% of all adult males who are homeless are veterans. According to the Georgia Department of Community Affairs 2015 Report on Homelessness, 12% of the state's homeless population are veterans. A 2012 Metro Atlanta Veterans Services Report that examined the quality and quantity of services available to Veterans in the Metro Atlanta area highlights the challenges faced by the state's Veterans. A total of 92 surveys (64% response rate) were completed by national and local nonprofits in a 10-county metro Atlanta area that provided services for Veterans. Approximately 82% of survey respondents working with Veterans believed that homelessness was a major problem in the veteran community. The major causes of homelessness cited by respondents included mental health disorders, substance abuse issues, and overall economic conditions (Georgia Center for Nonprofits, Metro Atlanta Veterans Services Report, 2012).

Approximately 75% of the 90 veterans surveyed in the above study reported known mental or physical health issues. About 58% had either a mental or physical disability. Approximately 32% of the disabled veteran respondents indicated they had a mental disability. Almost 29% of survey respondents had physical or mental health issues resulting from combat. Thirty-two percent of

the veteran respondents who had been or were currently homeless after military service indicated that substance abuse was the cause of their homelessness, but less than 4% had sought substance abuse treatment services. (Georgia Center for Nonprofits, Metro Atlanta Veterans Services Report, 2012)

PATH Outreach Teams identify, assess, link, and support homeless veterans who have a serious mental illness. Outreach staff collaborate with case managers from the Veterans Administration to engage homeless veterans in services, including regularly scheduled combined outreach activities. During these special outreach efforts all identified Veterans who agree to accept services are placed in VA Domiciliary emergency shelter and assisted in accessing all VA and other benefits they are eligible for. Regional gatherings of PATH providers and VA providers have resulted in greater collaboration to serve homeless veterans. For example, the New Horizon PATH Team has an annual homeless outreach event, with several vendor booths manned by VA and other veteran-serving agencies in the Columbus area. The Serenity PATH Team in Augusta hosts a similar event. During routine PATH site visits, providers are reminded of the special consideration regarding veterans as specified in Section 522 (d) of the Public Health Service Act.

PATH Staff are well-trained in military culture, PTSD, suicide prevention, and other topics needed to work effectively with homeless veterans. In FY 2014, PATH providers had the opportunity to participate in a statewide training curriculum, in cooperation with the CABHI State Supplement grant staff, specifically designed to increase skills and knowledge in addressing the needs of Veterans and military families, with much emphasis on serving homeless veterans with PTSD and other trauma-related illnesses. In SFY19, PATH teams had the opportunity to participate in Georgia's statewide veterans care conference, Unspoken Wounds. Several workshops focused on strategies to assist homeless veterans in finding permanent supportive housing, employment, mainstream and VA benefits, and behavioral health treatment and support services. In the past, DBHDD has also provided funding and support for Georgia's Star Behavioral Health Providers (SBHP), a training, dissemination and referral system aimed at expanding access to trained behavioral health providers for service members, veterans and their families. PATH Teams are offered two levels of training, with course content created by the Center for Deployment Psychology (CDP) that can assist them in working effectively with veterans:

- Tier One introduces military culture and information about the deployment cycle. Open to all service providers and community members.
- Tier Two provides education about specific challenges and difficulties that are often associated with military service. Open to all service providers who have attended Tier One.

The National Coalition for Homeless Veterans (NCHV) is the resource and technical assistance center for a national network of community-based service providers and local, state and federal

agencies that provide emergency and supportive housing, food, health services, job training and placement assistance, legal aid and case management support for hundreds of thousands of homeless veterans each year. The New Horizons PATH Team is a member of this Coalition, as are several of the agencies that PATH Teams partner with for housing and support services for individuals receiving PATH case management and housing support services, including Action Ministries, Gateway Center, Hope House, Decatur Cooperative Ministries, and the Salvation Army.

In 2012, Atlanta Mayor Kasim Reed signed on to President Obama's White House Mayor's Challenge to End Veterans Homelessness in 2012. As part of a national campaign with 14 cities, Atlanta not only exceeded the goal of re-housing 100 chronically homeless veterans in 100 days, but also housed more homeless veterans than any other city as part of this challenge in the United States. On May 20, 2015 Mayor Reed announced that the City of Atlanta had made significant progress in its effort to move all homeless veterans into permanent supportive housing, putting the city on a path to meet President Obama's goal of ending veteran homelessness across the country by 2015. The City of Atlanta Continuum-of-Care continues to work with federal, state and regional partners, including DBHDD and its Region 3 PATH Teams on campaigns to house veterans.

In December of 2016 DeKalb County Continuum of Care officials announced that DeKalb is the first county in Georgia to achieve "functional zero" for veteran homelessness, meaning any homeless veteran who will accept housing will receive it. According to The Atlanta Journal and Constitution (December 11, 2016) by September of 2016, 378 veterans were placed in permanent housing through the distribution of federal supportive housing vouchers and connecting veterans to other programs. Homeless veterans with SMI may also apply for DBHDD's permanent supportive housing option, the Georgia Housing Voucher Program with assistance directly from a PATH Team or through a DBHDD-contracted Comprehensive Community Provider. Through a five-year SAMHSA grant, Georgia had the opportunity to enhance service provider, law enforcement and criminal justice knowledge of working with Veterans. In 2008, Georgia was awarded the Jail Diversion and Trauma Recovery (JDTR) Priority to Veterans SAMHSA grant to develop a statewide infrastructure for Veterans involved in the criminal justice system that have been assessed with Post Traumatic Stress Disorder and to identify best practices for jail diversion programs and trauma informed care. The original pilot site for the grant was located in DeKalb County at the DeKalb Community Service Board and relocated to Savannah/Chatham County at the Gateway Community Service Board in FY10. An additional expansion site was started at Highland Rivers Health Community Service Board in the Appalachian Judicial Circuit (Fannin, Gilmer, and Pickens Counties) in FY13. Georgia served 180 individuals in the JDTR program. This project was staffed by a state Project Director and five local staff. General oversight and strategic planning were provided by a State Advisory Council made up of State agency representatives, VA, service provides, judges, law enforcement, and veteran consumers,

as well as two (2) Local Advisory Councils of similar representation. The local demonstration sites used Seeking Safety, an evidenced-based model of treatment for PTSD and Substance Abuse. Case management was provided to support those enrolled in the program by linking them to community resources and wrap-around services that addressed their recovery and reintegration needs. With the inception of Jail Diversion Programs for Veterans, Veterans Courts, and numerous Veterans Services Organizations, Georgia is highly engaged in meeting the needs of today's Veterans and their families.

DBHDD provided an extensive array of training opportunities through this grant to promote best practices for jail diversion programs and trauma informed care. From 2010 to September 2014, DBHDD offered a plethora of trainings, designed to further equip the state's workforce. Through its rollout of regional trainings for providers, DBHDD trained over 600 practitioners, supervisors, administrators, and consumer advocates across the state.

Trainings included:

- Trauma-Informed Care for Georgia Crisis Intervention Teams (CIT)
- Trauma-Informed Care for Veterans, Clinical Perspectives Related to Jail Diversion and Trauma Recovery
- Understanding Trauma Series
    - Understanding Trauma: There's Hope in Crisis
    - Understanding Trauma: Responding with Respect
    - Understanding Trauma: Empowerment through Reintegration
- Seeking Safety: A Model for Trauma and Substance Abuse
- Clinician Administered PTSD Scale (CAPS) Training
- Vet-to-Vet Peer Support Training
- Cultural Diversity
- In partnership with the Division of Addictive Diseases, sponsored a "Paving the Way Home: event for veterans, providers, state and federal agencies, and the VA
    - Military Culture & Terminology (STAR Behavioral Health Providers—DBHDD in partnership with the GA National Guard, Emory University BraveHeart Program, the Center for Deployment Psychology, Uniformed Services University of the Health Sciences, and the Military Family Research Institute at Purdue University

A 3-day statewide conference—Unspoken Wounds: One Team. One Battle. Many Victories!! Was held March 17-19, 2019 to promote a comprehensive system of care that addresses the treatment, case management, and reintegration needs of veterans and their families. The conference was attended by more than 300 individuals and was considered to be a huge success. In open-ended responses on conference evaluation forms, participants provided praise for the conference presentations. One participant noted the expansive content options, which provided

"an opportunity to crosswalk and integrate new and existing information together," while another indicated they were "so impressed by the amount and variety of topics." Participants also stated the "presenters were better than expected" and the "organizers did an outstanding job." One attendee stated, "I have been to quite a few conferences this year and this conference stands out as one of the best. It was very apparent that the presenters are very passionate about serving those members of society who have paid the ultimate price in order to serve us. The information presented was interesting and informative." DBHDD has been able to sustain this training post-grant period utilizing state funds. Sessions included:

1. Entrepreneurship for Transitioning Warriors
2. Career Coaching for Veterans
3. Beyond Loss: Myths, Strategies & Tools to Move from Grief to Growth
4. In the Middle of Nowhere: Rural Mental Health Services for Veterans
5. Supporting Military Women Through their Transitions from Soldier to Civilian
6. Veteran Peer Workforce: The Importance of Shared Experience in Recovery Intervention
7. Beyond the Office Walls: How alternative therapies help heal
8. Military Moral Injury (Part1): Standardized Assessment Tools and Identification of What is Lost
9. Military Moral Injury (part 2): Treatment Interventions and Coordinating Community Approaches
10. Re-entry: From In-reach to Outreach
11. Treating PTSD in Veterans using an IOP Model (IOP)
12. Warrior 2 Citizen: Home Life Transition Program (HLTP)
13. Co-occurring Disorders and the Homeless Veterans: Practical Solutions for Housing and Treatment
14. Saving Shelter Dogs, Supporting Trainers
15. Reclaiming Serenity Thru Mind-Body Practices: QiGong, Zero Balancing, CBCT® Meditation and Reiki
16. Assisted Outpatient Treatment (AOT) laws in GA
17. Emotional Hygiene: Making Self-Care Non-Negotiable
18. Healing, Health and Wellness: Gentle Yoga, Mindfulness and Meditation
19. Current Challenges and Future Directions Supporting Veterans After Military Sexual Trauma
20. Strengthening Partnering Experiences
21. Transitioning through Trauma: Strategies for supporting Veterans in higher education
22. Green Zone, Understanding the Military Member
23. Triple Win: Serving Veterans, Saving Shelter Dogs, Supporting Trainers
24. Trauma Informed Care for Veterans
25. Using Social Media to build Women Veteran Communities

26. Why Wait for a Crisis?: Getting Veterans into Community Treatment Through Deflection
27. Community Impacts of Veteran Treatment Court programs
28. Sierra Club Military Outdoor: Healing through the Outdoors
29. The Warriors Journey
30. Music Therapy: Why It is a Crucial Part of a Victorious Treatment Team
31. The Journey from Trauma to Post Traumatic Growth
32. Veterans Career Fair

The 5-day 2014 10th Anniversary Accountability Courts Conference: Different Paths, One Goal Conference, held in Atlanta, GA, was attended by 1,000+ people. While DBHDD had partnered in a more general way to co-sponsor the event in 2012, the more specific and detailed work in 2014 helped to ensure that the cross-training needs of GA's behavioral health providers, law enforcement, court personnel, government agency, non-profit, faith-based, and other Veteran-serving social service agencies can be addressed in multiple arenas each year. The Veterans Track included 23 workshop sessions. A sample of sessions is listed below:

- Arts, Expressive Arts Therapies, Technology, Dreamwork, and Equine Therapy: Healing Interventions
- Veterans Treatment Court: Mentor Bootcamp (first in the state)
- The Role of Veterans Justice Outreach (VJO) Workers in Veterans Treatment Courts
- Focusing on the Importance of Veterans Treatment Courts (Keynote address by Judge Robert T. Russell, Buffalo Veterans Treatment Court)
- Law Enforcement Tools for Supporting Veterans in Transition
- Addressing Trauma, Addictive Disease and Other Co-Occurring Disorders with Veterans & Others
- Have You Ever Served in the Military? An American Academy of Nursing Awareness Campaign Initiative
- Are We There Yet? Skills and Strategies for Supporting Military Children Through Transition
- Special Considerations for Working with Homeless Veterans
- Employment Initiatives for Returning Veterans
- Veterans Courts in Georgia: Our Veterans Deserve This Treatment
- Understanding and Accessing Veteran Benefits
- Coalition Building for Effective Service to Veterans and Military Families
- Transitioning from Combat to the Civilian World
- Cognitive Behavioral Therapy, Virtual Reality Applications in the Treatment of PTSD for the Wounded
- Public Safety De-Escalation Strategies for Military Veterans in Crisis

DBHDD is member of Georgia's Returning Veterans Task Force (RVTF), a legislatively mandated intra-state task force that investigates how Georgia's state government agencies can coordinate services, to include behavioral health services for veterans and their family members, to better assist service members transitioning from active duty back into society. Including the Georgia Department of Veteran Services (GDVS), which coordinates the group, the RVTF is comprised of 12 member agencies and organizations, including:

- DBHDD
- Department of Community Health
- Georgia Department of Defense
- Department of Human Services
- Department of Labor
- Secretary of State
- Georgia Veterans Education Career Transition Resource Center (VECTR)
- Council of Accountability Court Judges
- Technical College System of Georgia
- University System of Georgia
- Workforce Division of the Georgia Department of Economic Development

DBHDD brings behavioral health expertise and resources to the table to assist with identification and coordination of treatment, support services, and other state resources for veterans and their family members with mental health challenges, substance use disorders, or intellectual and developmental disabilities.

Limited English Proficiency and Sensory Impairment (LEPSI)

Georgia is a culturally diverse state with many spoken languages. The Department of Administrative Services (DAOS), through a competitive procurement process, selects qualified interpreting service vendors to accommodate all interpreting service needs for state agencies. DBHDD operates a policy on the provision of meaningful language access to all programs and activities conducted or supported by the department. In FY11, a LEPSI Contract Expectation was added that requires all contracted service agencies to offer meaningful communication assistance at no cost to the consumer. Due to the lack of bi-lingual and sign fluent mental health practitioners, providers rely upon interpreters to facilitate communication between practitioners and consumers with limited English proficiency and sensory impairment. DBHDD maintains agreements with qualified Language Service Vendors to provide interpreting services to state and contracted services at pre-determined rates.

DBHDD is committed to providing reasonable accommodations to facilitate effective communication when accessing services DBHDD itself provides. For individuals with limited English proficiency, DBHDD provides language assistance services, including translated

documents and oral interpretation, free of charge, when such services are necessary to provide meaningful access to services DBHDD itself provides. For individuals with sensory impairment, DBHDD provides appropriate auxiliary aids and services, including qualified interpreters and information in alternative formats, free of charge, when such aids and services are necessary to provide meaningful access to services DBHDD itself provides.

The responsibility for coordinating accommodations for DBHDD field offices is assigned to the Behavioral Health Field Office Access Coordinator (BH-FOAC) for each region, as identified by the Director of Field Operations, Division of Behavioral Health, and the Developmental Disability Field Office Access Coordinator (DD-FOAC) for each region, as identified by the Director of Field Operations, Division of Developmental Disabilities. The BH-FOAC and DD-FOAC serve as a resource for inquiries about, and oversight of, communication accommodations. Policy 15 -103 details the responsibilities of the BH-FOAC and the DD-FOAC in relation to facilitating effective communication for individuals receiving services that DBHDD itself provides in the regions.

Additionally, as mentioned above, the DBHDD and DCH implemented a 2017 expansion of telemedicine policy to allow individuals who speak a language other than English to access any practitioners who speak their language via telemedicine (including ASL).

Deaf, Deaf-Blind, and Hard of Hearing Populations

It is Georgia's vision that all individuals, including individuals who are deaf, deaf-blind, or hard of hearing and utilize ASL as a preferred language, have easy access to linguistically accessible and culturally competent high-quality care that leads to a life of recovery and independence.

Identification of Individuals with Hearing Loss. Paramount to providing high-quality services is the thorough understanding of the population served. Toward that end, DBHDD added nine mandatory demographic questions for providers to better identify individuals with hearing loss. These questions tentatively establish the hearing/vision status and language modes/preference of all individuals seeking services. A DBHDD policy titled "Provider Procedures for Referral and Reporting of Individuals who are Deaf, Deaf-Blind, and Hard of Hearing" requires DBHDD providers to notify the ODS of an individual with hearing loss within 48 business hours of referral or contact.

Identification of Communication Preferences and Needs. Once an individual with hearing loss is identified, ODS Communication Assessors conduct a Communication Assessment to identify the individual's communication access needs and preferences. Accommodation recommendations are documented in the ODS Communication Assessment Report. If an individual chooses not to receive recommended ODS accommodations, they may waive such services. A DBHDD policy titled "Communication Assessment Procedures for Individuals with Hearing Loss" provides the

objectives of the communication assessment and specifies that providers are expected to use this document in understanding the required communication needs of the individual while they are accessing DBHDD services.

Development of Statewide Community-Based Accessible Services. In August 2015, ODS signed a contract with Avita Community Partners to hire an ASL fluent therapist and an ASL fluent Case Manager to provide culturally and linguistically affirmative behavioral health services to individuals who are deaf, deaf-blind, and hard of hearing in Avita's Community Service Area and designated neighboring areas. This contract has been expanded to allow Avita to partner with all CSBs to provide ASL fluent services to individuals who are deaf, deaf-blind, and hard of hearing in every county in the state, either on-site or via telemedicine. A DBHDD policy titled "Accessibility of Community Behavioral Health Services for Individuals Who are Deaf and Hard of Hearing" outlines the expectations that providers endeavor to offer direct communication via an ASL fluent therapist to individuals who prefer that approach. This policy also has instructions on how providers can book and schedule interpreters, how the providers can work with sign language interpreters as well as basic expectations for providers should they desire to hire staff interpreters, or ASL fluent clinicians or case managers.

Workforce Development of Qualified Mental Health Interpreters (QI) and Georgia Behavioral Health Interpreters (GaBHIs). With few ASL-fluent behavioral health professionals practicing in Georgia, service providers must rely upon QIs and GaBHIs to provide appropriate access to services. In addition to the nationally recognized credential of a QI, DBHDD has established a state-centric behavioral health interpreter designation, GaBHI. DBHDD offers ten scholarships annually for local interpreters to attend the Mental Health Interpreter Training (MHIT) in Montgomery, Alabama as a first step in becoming a GaBHI. After attending MHIT, these interpreters are required to obtain a total of 40 hours in practicum with supervision from a qualified supervisor. To date, more than 35 interpreters have attended MHIT or an equivalent training to begin the process of earning a GaBHI designation. DBHDD has hired 13 of these and three are GaBHIs. (As well, the QI and the GaBHI credential are held by the interpreter coordinator for DBHDD). QI and GaBHI interpretation services are available to DBHDD Mobile Crisis Services Providers 24/7, either in-person or via HIPAA-compliant browser-based video relay.

Deaf Services Provider Training Series. In addition to the above efforts, ODS is committed to making basic training available to all providers to increase communication skills and cultural competency among non-signing service providers to promote a supportive trauma-informed care environment and reduce possible communication barriers. This training includes the utilization of accessible informational materials (videos, visual aids, auxiliary aids, etc.) to bridge communication gaps in the temporary absence of Qualified Mental Health Interpreters (QI), GaBHIs or ASL-fluent professionals. ODS has developed a webinar for Crisis Providers directly

targeting the Deaf/Hearing Loss population who may or may not communicate in sign language. Additionally, ODS has provided a webinar that has been modified to meet the needs of community behavioral health providers.

Promotion of Public Information Awareness and Community Outreach. Essential to utilization of behavioral health services, is the public's awareness of the availability of those services. Toward that end, ODS has promoted education and awareness of DBHDD's increased provision of accessible services. These efforts going forward will include development of ASL translations of available services and written materials, hosting Deaf Community Conversations for the community, and attendance/sponsorship of numerous state conferences and local Deaf community events.

Criterion V: Management Systems

Fiscal Resources

The FY20 total annual budget for adult mental health in Georgia is $457,387,413 million. Of the total adult mental health budget, about 86% goes to fund community- based services. The remainder funds state hospitals. Of the adult budget 97% comes from state dollars, and 3% of adult community mental health is funded with federal dollars.

As part of the ADA Settlement Agreement, in FY12, DBHDD was appropriated $32,013,761 in the amended budget for the last quarter of the fiscal year; for FY 13 appropriated $52,356,013; in FY14 appropriated $73,913,477; in FY15 appropriated $97,997,387; in FY16 $2,313,015; in FY17 $6,133,276; in FY18 $7,756,876; and in FY19 the Department was appropriated $5,721,600. These funds support the expansion of community-based mental health services. In addition, part of this funding supports community transition needs of consumers being discharged from the state hospitals, particularly some transportation funds, etc., and there is increased staff capacity to meet the obligations of the Settlement Agreement.

The total amount of Mental Health Block Grant funding available for adult mental health services and administration in SFY20 is $15,178,419, and of this amount, $14, 421,645 is provided for Supported Employment, Peer Support Services and Mental Health Treatment Courts. An additional $783,016 is available to support other activities such as provider training, Georgia Mental Health Consumer Network for Peer Mentor development, the Peer Specialist Training and Certification Program, support to the Georgia Behavioral Health Planning and Advisory Council and state administration.

Human Resources

DBHDD has actively sought to improve its workforce to better deliver quality services. Certified Peer Specialists (CPSs) have added tremendous value to the workforce as trained recovery specialists. CPSs are required staff for Assertive Community Treatment teams, Core

Services and Peer Supports and Coordinated Specialty Care teams for the LIGHT-ETP for first episode psychosis. In addition, they are recommended staff for Psychosocial Rehabilitation.

In order to provide a pool of qualified applicants for these positions, DBHDD, through a contract with the Georgia Mental Health Consumer Network (GMHCN) developed a training and certification program for CPSs. While several states have utilized Peer Specialists in service provision, this was the first certification program to be developed anywhere in the country. Block grant funds support staff positions at GMHCN to implement and monitor the certification program. Additionally, block grant funds are utilized to conduct the training and continuing education activities.

The driving force of DBHDD's system transformation is the continued development of the certified peer workforce. Agents of recovery and transformation, Georgia's CPSs inspire and support adult mental health consumers to recognize their dreams, preferences and strengths, and to learn skills to take responsibility for their recovery and creation of a meaningful life. As in any successful marketplace, the needs and desires of consumers transform the characteristics and delivery of services. CPSs advocate for and support development of the consumer voice. And, as employees of community behavioral health service providers, state-run psychiatric hospitals, regional and state DBHDD offices, as well as advocacy and other mental health system stakeholder organizations, CPSs are actively involved in shaping, defining and delivering consumer-directed, recovery-oriented services, that transform lives and systems.

The Georgia CPS Project, operating since 2001, is administered via the contract with GMHCN. The Director of the DBHDD Office of Recovery Transformation partners closely with the Executive Director of GMHCN to provide consultation and technical assistance on the development and utilization of Georgia's adult mental health peer workforce.

Georgia's utilization of peer specialists is expanding. With funding from a SAMHSA Transformation Transfer Initiative grant, Georgia created a standardized curriculum to certify CPSs to provide health and wellness supports. Certified Peer Supported Whole Health and Wellness Coaches work in partnership with a registered nurse to support individuals with behavioral health conditions in setting and achieving health goals related to overall mind-body wellness. A pilot program for forensic peer specialists was started in FY15 to support individuals with behavioral health conditions who are in prison to successfully transfer to the community.

The Certified Addiction and Recovery Empowerment Specialist (CARES) program is administered via a contractual partnership with the Georgia Council on Substance Abuse (GCSA). GCSA conducts the CARES Academy, which teaches individuals how to use their lived experience with recovery from substance use to support their peers in recovery. Individuals

who complete the 40-hour experiential classroom work and pass the certification test become Certified Addiction and Recovery Empowerment Specialists (CARES). CARES (aka CPS-AD) and provide peer support services to people with substance use disorders in Georgia's continuum of care.

In FY15 DBHDD implemented The Recovery-Focused Change Initiative pilot training and technical assistance in best practices associated with facilitating sustainable recovery-focused change in provider agencies. Each provider established a Recovery Change Team consisting of various agency staff, consumers, board members, family members and other stakeholders and participated in a 2-day workshop that included team building activities, stories about and examples of ways other agencies successfully transitioned to a recovery-focused service agency; and an opportunity to discuss and choose 4-6 projects the change team would like to work on at their agency. Technical assistance was provided to each change team after the 2-day training, to support them in completing their projects and continuing on their path to recovery transformation. The Recovery-Focused Change Initiative will continue in FY18, as a significant component of DBHDD's strategic plan to be transform to a Recovery-Oriented System of Care.

DBHDD recognizes the critical importance of staff development and training in strengthening adult mental health services in Georgia. The Office of Adult Mental Health in conjunction with the training department for the agency coordinates training and facilitates the many training and development activities offered through DBHDD. Some training initiatives are generated in response to gaps and challenges identified by various reviews and audits and others are developed as a result of quality improvement activities. All trainings are intended to improve the clinical skills of providers with whom the Department contracts for service delivery.
The Office of Adult Mental Health in collaboration with the DBHDD University, facilitates training and development activities on topics identified by the Office of Adult Mental Health During FY 2018 and FY 2019, there were several broad areas that received attention for adult mental health services training:

BECK INITIATIVE

- DBHDD is contracting with the University of Pennsylvania's Aaron T. Beck Psychopathology Research Center to provide recovery-oriented cognitive therapy (CT-R) training workshops and group consultation for select state hospital and community provider staff. The purpose of the training is to provide tools to clinicians to engage individuals with persistent schizophrenia in one-on-one psychotherapy in the community. The intended result is to help individuals with severe mental illness sustain themselves in the community, anticipate and overcome challenges, and further progress toward recovery. Training, consultation and sustainability activities continue for providers statewide.

- **Mental Health First Aid (MHFA)** training April 25, May 1, 23, June 9, 16, 2017 was offered to contracted paraprofessional staff and Certified Peer Specialists (CARES included) of DBHDD contractors who provide Adult Mental Health Supported Employment, Community Residential Rehabilitation, PATH, Forensic Peer Mentor services and other adult community mental health services. Mental Health First Aid training is a groundbreaking public education program that;
    - introduces participants to the risk factors & warning signs of mental health and co-occurring substance abuse disorders;
    - builds understanding of the impact of behavioral health disorders & common treatments
    - teaches participants a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer and self-help resources.
    - promotes mental health literacy, combats the stigma of mental illness and enables early behavioral health intervention.

- Community Residential Rehabilitation services training February 20, 21, 27, April 26, 27 and May 1, 2017. This three-part series of trainings was geared toward preparing providers to deliver Medicaid reimbursable residential rehabilitation services, and operationalizing the draft new CRR service definitions. The first training session of this series was offered in December, the second session was offered in February. This training enhanced adult mental health residential providers' knowledge, understanding and ability to deliver and be reimbursed for Medicaid billable residential rehabilitation services that promote community integration and housing stability.

- Trauma Informed Care Training April 20, 21 and March 27 and 28, 2017. This training focused on promoting an understanding of and ability to effectively support various types of trauma that may present in the population served by our AMH community services. This was a two-day training, for providers of ACT, CST, ICM, CM, and CSU services.

- ANSA/CANS training 3/26/19, 3/27/19. This training was for all contracted providers who facilitate functional assessments; all clinical supervisors, and clinicians/practitioners such that any DBHDD contracted provider of child/adolescent, adult mental health and addictive disease services who has responsibility for administering and/or supervising staff who administer the ANSA and or CANS will be trained to do so.

- Housing First training January 9, 10, March 14, 15, 16, May 10, 12, June 12, 13, 14 2017. This three-part training series was geared toward supporting our network of providers incorporation of recovery-oriented practices that promote increased choice and transition into independent supported housing for Individuals accessing our services. This training

was provided for all DBHDD contracted Providers of the following Community Based Adult Mental Health Services; Assertive Community Treatment (ACT), Community Support Team (CST), Intensive Case Management (ICM), Case Management (CM), and Projects for Assistance in Transition from Homelessness (PATH).

- Integrated Dual Diagnosis Treatment training, June 1, 2, 7 and February 13, 14, 15, 2017. Integrated Dual Disorder Treatment (IDDT) Advanced Training. This was an advanced level training, participants developed an enhanced understanding of principals and practice standards for IDDT, and increased their knowledge and ability to utilize effective strategies and techniques to support the complex addictive disease and mental health needs of the population of individuals accessing ACT and CST services.

- Community Housing Resources training June 26 and 27, 2017. This training focused on promoting awareness of resources that support access to safe and affordable housing options for the individuals served in adult mental health. The partnership with the Department of Community Affairs (DCA) was highlighted, which has allowed for an increase in access to the array of rental assistance programs for the target population such as the DCA housing choice voucher and HUD section 811 program.

- Transition Planning March 2, 3, 7, 8, 13, 2017. Participants received information about the overall transition planning policy. In addition, they were provided an understanding of the components of the transition planning process and the procedures that comprise it, including the specific steps of the procedures and documentation that captures the outcomes of those procedures.

- Maternal Mental Health training February 2, 21, 28, 2017. This training focused on the behavioral health needs of pregnant and or postpartum women. Mood disorders, particularly depression, are one of the most common complications during and after pregnancy, another related complication- postpartum psychosis is also a serious illness that can be quite severe. This training content will include signs and symptoms of Perinatal Mood and Anxiety Disorders, screening and treatment options and best practices in supporting the behavioral health needs of this population.

- Coordinated Entry and HUD Program Eligibility December 12, 2018. Coordinated entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs.

- The Right Response training provides specific behavior management skills and techniques for providers who support individuals in residential type settings. March 11, 12, 13, 2019

- Housing Quality Standards Wednesday, February 20, 2019. The Housing Quality Standards (HQS) set acceptable conditions for interior living space, building exterior, heating and plumbing systems, and general health and safety in a dwelling.

- Fair Housing Wednesday, April 24, 2019. The Fair Housing Act is a federal act in the United States intended to protect the buyer or renter of a dwelling from seller or landlord discrimination.

- Motivational Interviewing- November 2018

- ACT and CST TL Retreats 6/22/18, 7/12/19

Crisis System Optimization

Consultants from RI International provided training in two phases. Phase one offered a one-day training that was repeated in Northern, Central and Southern Georgia. The focus of phase one was on orienting current providers to new model of crisis services that focused on the needs of the community as a whole. Topics addressed were:

- Peer engagement as an integral component of crisis service delivery
- Managing and supporting a peer workforce in a crisis environment
- No force first: Active recovery-oriented treatment in crisis settings
- Welcoming spaces: lobby and intake area
- Keys to improving throughput: observation area structure and function
- Tracking cost avoidance: Acute inpatient diversion
- Strengthening first responder relationships and emergency department diversion
- Changing the law enforcement relationship: No refusal of crisis referrals
- Crisis system structure to meet the needs of the community

Phase II training followed a round of site visits by consultants and revolve around three recurring themes informed by the visits. These themes were; enhancing patient engagement, the role of peers in crisis work, and creating lasting culture change. To this end, the RI International Consultants conducted 3 specific trainings:

- A train the trainer presentation on the AIDET model of patient engagement. This training included fidelity measures and tools to incorporate the model into all aspects of supervision.
- A deeper dive on utilizing peer supports to engage patients and enhance throughput
- An in-depth presentation on sustainable culture change utilizing Gallup research and practical applications around "the 12 questions".

COMMUNITY BEHAVIORAL HEALTH SYMPOSIUMS October 2018 and upcoming in October 2019

- Adult Mental Health Training:
  2-Day training and technical assistance for community behavioral health providers of adult services. Providers to learn about best practices, outcome achievement, strategies to assist in treatment interventions, hear from peers, and understand expected treatment outcomes for targeted populations.

SUPPORTED EMPLOYMENT

- A series of 12 session webinars provided to SE staff on the Individual Placement and Supports (IPS) model of SE: September- December 2016.

THE BASICS

- In order to ensure that paraprofessionals who provide behavioral health services have met basic training expectations, DBHDD continues to utilize the online learning vendor, Relias (formerly Essential Learning) to provide standardized training preparing paraprofessionals to work in the field of mental health; all paraprofessionals are required to complete required courses shortly after hire. Required topics include:
  - Corporate Compliance
  - Cultural Competence/Diversity
  - Documentation
  - Understanding Mental Illness – Addictive Disorders
  - Pharmacology and Medication Self Administration
  - Professional Relationships
  - Recovery Principles
  - Safety/Crisis De-escalation
  - Service Coordination
  - Suicide Risk Assessment (Must choose at least 2 hours of online training)
- Key trainings on basic topics such as documentation and incident investigation are routinely offered for DBHDD providers.
- DBHDD University offers a Learning Management System (LMS) that provides online educational opportunities for both DBHDD staff and contracted community service providers. The LMS provides for course registration, record of course completions, assessment grades, transcripts, and printable course certificates.
- The Administrative Service Organization provides basic orientation to newly enrolled providers including basic utilization management (prior authorization, continued stay reviews, discharge processes), quality management reviews, and compliance.

Community behavioral health services in Georgia are provided through a number of contracted public and private provider agencies. These are not state agencies and therefore we do not have

specific knowledge about the numbers of staff of differing professional disciplines that are employed by each agency. Staffing requirements for services within the Georgia Behavioral Health system are established in both the DBHDD *Provider Manual for Community Behavioral Health Services* and the Medicaid Services Manual. Practitioners are divided into Professional and Paraprofessional categories, and licensed behavioral health professionals practice under the scope of relevant practice laws. Paraprofessionals are those practitioners who are not licensed or certified and must complete a standardized curriculum approved by the Department of Community Health and DBHDD. Each service definition contains specific staffing patterns that include the required level of supervision by a licensed practitioner, as well as staff to consumer ratios that meet standards of care. Urban areas of the state generally have more access to all categories of professional staff. The Health Resources Services Administration (HRSA) has designated many parts of the state as "Mental Health Professional Shortage Areas," highlighting the fact that recruiting and retaining qualified staff presents a continuous challenge to rural providers. While shortages of all levels of professional staff exist within the Georgia system, concerted efforts are being made to secure qualified staff for services provision. Georgia strategically continues to grow the guild of Certified Peer Specialists to assist in promoting access and engagement while the workforce shortage persists.

Disaster Preparedness

DBHDD has a Disaster Mental Health Coordinator's (DMHC) position which is fully funded by the Georgia Department of Public Health. DBHDD's DMHC works with the Georgia Emergency Management Agency and other emergency preparedness agencies to ensure that the behavioral health needs of Georgia residents are included in state-level plans by participating in numerous workgroups and task forces. The DBHDD Regional Hospitals and provider agencies are members of Regional Emergency Preparedness Healthcare Coalitions throughout the state and they participate in exercises with local healthcare and emergency preparedness partners. ACT, CST, ICM, CM, and SE providers receive training in continuity of operations and personal disaster planning as well as training on how to work with individuals to develop a personal disaster plan. Georgia's disaster mental health website at www.georgiadisaster.info contains information and resources on disaster mental health planning. DBHDD has a continuity of operations plan policy for its state office and policy that requires continuity of operations for all contracted providers. Disaster mental health training and exercises takes place throughout the state several times a year.

Emergency Services Worker Training

All services in the Georgia DBHDD system are provided under contract or agreement with private or public providers of behavioral health services. Local providers work with emergency personnel such as Sheriff's Departments, Hospital Emergency Rooms and county jails on issues related to consumers with behavioral health needs. The local providers educate these responders on the needs of consumers as well as on the services available through their agencies. In

particular, in areas that are more rural, provider staff develops relationships with local hospital emergency rooms and other responders to keep them apprised of the unique needs of persons with mental illness and serious emotional disturbance in emergency situations. In the more metropolitan regions, the providers sometimes contract with outside vendors to do training of emergency personnel.

Behavioral Health Link provides information and marketing materials regarding the Georgia Crisis and Access Line to hospital emergency room personnel and local law enforcement staff. The intent is for all emergency services personnel to be informed of the availability and process for accessing 24/7 crisis response for any individuals in a crisis related to mental illness or addictive diseases.

In September of 2016, Governor Nathan Deal announced a law enforcement reform package that includes a multi-phase overhaul of officer training and certification courses. The reform package includes enhanced resources for Georgia Crisis Intervention Team (CIT) and a provision that will involve the transfer of CIT to the Georgia Public Safety Training Center (GPSTC), thereby streamlining training requirements and increasing access to more than 57,000 state and local officers. DBHDD now blends funds with GPSTC, to provide CIT training to Georgia's law enforcement officers using a curriculum that blends best evidence based practices from the new Bureau of Justice Assistance (BJA) CIT Model, the Memphis, Tennessee CIT model, and data gained from CIT practice in the field since 2006 In an effort to reduce the stigma associated with mental illness, the Georgia CIT Program's vision is a Georgia where citizens with serious mental illness receive medical treatment in lieu of incarceration. Georgia adopted a top-down approach to training law enforcement by forming a collaborative with executives from key departments of state government, mental health providers and advocacy organizations.

From FY06 through FY17, the CIT (Crisis Intervention Team) Program collaboration between NAMI Georgia and DBHDD trained police officers across the state to divert consumers from incarceration and link them to treatment services. In FY17, 55 CIT trainings were conducted reaching more than 1,000 law enforcement officers. In response to requests from local law enforcement agencies wanting to increase their numbers of officers with at least some knowledge of behavioral health issues and response prior to their being able to attend the full week-long CIT course, NAMI facilitated a new DBHDD-funded Introduction to Behavioral Health Crisis curriculum--seven (7) 16-hour courses for Law Enforcement Officers waiting to attend the 40-hour CIT class, and eight (8) 8-hour courses for First Responders and 911 Operators— The goal and objective of the new **training** is to provide an in-service introductory course on behavioral health crisis for law enforcement officers as a precursor to the Georgia CIT Program. Components of the new class include:

1. An introduction to signs and symptoms of the behavioral health disorders law enforcement officers are most likely to see during their day-to-day encounters with citizens experiencing behavioral health crisis, disorders such as Depression, Bipolar Disorder, Post Traumatic Stress, Schizophrenia and Autism.
2. Statistics on the prevalence of mental illness, including information on incarceration rates, suicide, homelessness, recovery success rates, and the impact of stigma.
3. A basic overview on Legal Issues highlighting some of the Official Codes of Georgia relative to 1013, Probate Orders (OTA), transports, immunity, HIPPA, case law citing deliberate indifference, and Georgia Accountability Courts.
4. Community resources including information on the Department of Behavioral Health and Developmental Disabilities (DBHDD), Behavioral Health Link (BHL), Community Service Boards (CSBs), Advocacy and Recovery organizations such as National Alliance on Mental Illness (NAMI), Georgia Mental Health Consumer Network (GMHCN), Georgia Parent Support Network (GPSN), and the Georgia Council on Substance Abuse
5. Consumer Perspective featuring an "In Our Own Voice" presentation by a person living in recovery with mental illness. The presenter shares dark days of mental illness, acceptance, treatment, success hopes and dreams.
6. The last module will be an introduction to CIT, citing the history of CIT, benefits of CIT training, successful CIT outcomes, and skills taught during the course.

The state's Crisis Intervention Team Training Manual states that one of the main collaborative objectives between the GBI and NAMI is to "Ensure that people with mental illnesses and other brain disorders always receive treatment, in lieu of incarceration in most cases."

The Georgia Bureau of Investigation (GBI) has incorporated a module on trauma into its monthly training for new Crisis Intervention Team (CIT) State Patrol officers across the state. The training includes interviews with actual consumers who have received services for PTSD, education on the signs and symptoms of trauma and other mental illnesses, as well as de-escalation techniques for use in working with persons in crisis related to trauma. A goal of the CIT training program is that officers understand that involvement in many infractions of the law may be a result of a person's trauma history or failure to receive proper trauma-informed treatment, rather than a result of intentional wrongdoing.

The FY18 transition of CIT to GPSTC will allow for expansion of CIT training to at least double the number of officers reached in previous years, and will allow for development of "CIT University". New online training modules will be developed to provide advanced add-on training for CIT certified officers. Modules may include trauma, similar to the current GBI module, Alzheimers and Dementia, veterans, youth in crisis, autism, and other topics designed to increase officers' knowledge and improve responses in the field.

DBHDD's Assistant Director of Adult Mental Health Services is the Program Manager for the GPSTC contract and one of AMH's Behavioral Health Treatment Court Liaisons is a member of the GPSTC Crisis Intervention Team Training Advisory Board.

CHILD AND ADOLESCENT MENTAL HEALTH

Criterion 1: Comprehensive Community-Based Mental Health Service System
DBHDD provides a comprehensive community-based system of mental health care for children and adolescents with serious emotional disturbances (SED) and their families who need public services. The mission of the Office of Children, Young Adults, and Families (OCYF), is to provide for a comprehensive, quality public mental health system for children, young adults and families. OCYF offers children, young adults and their families, a range of treatment and support services to address emotional and behavioral disorders. Early treatment is critical to helping youth cope with isolation, stigma, and other challenges involved in living with SED. Youth with SED have diagnosable mental, behavioral, or emotional concerns, which are persistent and interfere with their family life, community activities and school. They need a range of treatment and support services that allow them to live at home whenever possible, continue school and take part in community life and childhood activities. Youth with substance use challenges have diagnosable substance use disorders as a primary diagnosis and many have both SED and substance abuse co-occurring disorders that need specialized treatment interventions and approaches.

DBHDD has made efforts to expand community-based mental health services for youth and their families. The first funding for community-based child and adolescent mental health service expansions was appropriated by the state legislature in FY89 and totaled $450,000. The total amount of state and MHBG funding available for FY19 in Child and Adolescent Community Mental Health is over $77 million. An array of community based mental health services is provided in each service area of the state. While not all services are available in every one of Georgia's 159 counties, each county is included in one of the state's six regions. The full array of services is provided in the lead counties of the services areas, at a minimum, with some services available in satellite offices or through mobile service delivery.

Through a standardized provider application process, organizations are encouraged to apply to become authorized providers to increase consumer choice. All Behavioral Health providers under contract with DBHDD must adhere to the Department of Behavioral Health and Developmental Disabilities Provider Manual Community Behavioral Health, which includes requirements and utilization guidelines for all providers. The requirements identified in the manual assure that an organized system of care is available to citizens of Georgia wherever they live in the state and according to individual need. Services are required to be provided in a culturally appropriate and competent manner by providers with a workforce trained to recognize

and address diverse needs. All Providers must be accredited at the time of application and continuously recredentialed by one of the following organizations: The Joint Commission (TJC), the Council on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the Council on Quality and Leadership (CQL).

As indicated in the Adult Mental Health section of this application, DBHDD has implemented a Tiered Provider Network. This same Tiered approach applies to child and adolescent mental health and substance abuse services. Tier 1, Comprehensive Community Providers (CCPs), must provide services to children, adolescents and emerging adults. Community Service Boards are Tier 1 providers and the established safety net and public providers of behavioral health and developmental disability services in Georgia. They provide outpatient behavioral health services and specialty services. In addition to the 24 Community Service Boards, a network of private providers offers an array of community services for youth with SED. There are 108 Tier 2, Medicaid only providers and 40 providers of specialty services (Tier 3) such as Intensive Family Intervention Services and Resiliency Clubhouse Services. Each provider, whether public or private, has a Letter of Agreement or contract to provide services.

Provider contracts and agreements identify who is to be served with DBHDD funding. Because of growing pressure for services using the public dollar, it became imperative to identify those eligible to receive services, and the level of services to be offered. A "Core Customer" definition was developed which has as its foundation the elements of the federal definition for SED. This eligibility criteria better defines the population of youth to be served utilizing state and federal resources, within the public mental health system. The definition is addressed in the Unmet Need section of this MHBG plan.

The target population for DBHDD to serve changed with the implementation of managed care for those eligible for Medicaid. DBHDD is not responsible for providing behavioral health services to all youth with behavioral health conditions. The public behavioral health benefits in Georgia are covered through a variety of mechanisms.

- CHIP-covered youth are served through four (4) managed care organizations (CMOs) which are procured and managed by the state's Medicaid authority, the Department of Community Health (DCH);
- Youth in the custody of the state through the Departments of Human Services and/or Juvenile Justice are served through a single managed care organization which is procured and managed by the state's Medicaid authority, the DCH (this contract also allows adoptive assistance families to option this coverage);
- Youth who qualify for Medicaid as "disabled" are served by a fee-for-service benefit plan which is collaboratively implemented by the DCH and the DBHDD;
- Youth who are uninsured are served by a fee-for-service benefit plan which is implemented by DBHDD; and additionally

- Some youth may have limited behavioral health coverage by private insurance plans and may qualify for some ancillary support through state and federal funds.

The benefit plans required of the CMOs are designed in collaboration between the DCH and DBHDD (which are approved under the Medicaid Rehabilitation Option), but the DCH allows the CMO vendors to uniquely carry out aspects of the benefit, including medical necessity criteria, authorization parameters, and determination of provider qualifications. Many of the DBHDD providers are enrolled with the CMOs.

The majority of children's services administered by the DBHDD are paid utilizing a Fee for Service method. DBHDD moved to a Fee for Service Model for state funded services whereby the majority of funding available for child and adolescent behavioral health services is no longer allocated through a contracting process. All of the Essential Services and Intensive Family Intervention (IFI) services are provided through this method. Because DBHDD has a finite amount of state funding available for services, the agency must monitor utilization and expenditures to maintain budget stability. To that end, DBHDD implemented a review process to monitor providers' use of state funds to ensure that no other third-party resources are available to cover the cost of service. Some specialty services, such as crisis stabilization units, mobile crisis services, Care Management, and Resiliency Clubhouses are provided through contracts.

Below are brief descriptions of services provided to children and adolescents from the DBHDD Provider Manual:

C&A Non-Intensive Outpatient Services

- **Behavioral Health Assessment**

Face-to-Face comprehensive assessment with the individual that includes the individual's perspective (and that of family and significant others as well as collateral agencies/treatment providers).

- **Diagnostic Assessment**

Psychiatric diagnostic interview examination completed in a face-to-face format (which may include the use of telemedicine) and may include family and other sources.

- **Psychological Testing**

Face-to-face assessment of emotional functioning, personality, cognitive functioning or intellectual ability using objective and standardized tools that have uniform procedures for administration and scoring, and utilizes normative data upon which interpretation of results is based.

- **Crisis intervention**

Designed to prevent out of home placements or hospitalization. Time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services.

- **Medication Administration**

An assessment, by the licensed or credentialed medical personnel administering the medication, of the youth's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the youth to the physician for a medication review. Education to the youth and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with youth's resiliency plan, must also be included.

- **Nursing Assessment and Health Services**

Requires face-to-face with youth/family/caregiver to monitor, evaluate, assess, and/or carry out a physician's orders regarding the psychological and/or physical problems and general wellness of the youth.

- **Psychiatric Treatment**

The provision of specialized medical and/or psychiatric services, including medication management and psychiatric psychotherapy, assessment, and monitoring, performed by a Board-Certified medical doctor licensed in the State of Georgia.

- **Community Support**

Rehabilitative, environmental support and resource coordination considered essential to assist a child/youth and family in gaining access to necessary services and in creating environment that promote resiliency and support the emotional and functional growth and development of the child/youth.

- **Family Counseling**

A therapeutic intervention or counseling service (successful with family populations) directed towards specific goals defined by youth and parent(s)/responsible caregiver(s) conducted by licensed staff, and specified in the Individualized Resiliency Plan.

- **Family Training**

Systematic interactions between identified individual, staff, and family directed towards restoration, development, enhancement, or maintenance of functioning of individual/family unit. This may include support of family, as well as training and specific interventions/activities to enhance family roles, relationship, communication and functioning

promoting resiliency of family unit. This is directed toward the achievement of specific goals defined by the youth, parent(s), or responsible caregiver(s).

- **Group Counseling**

Group based therapeutic intervention or counseling service successful with populations, diagnoses, and needs. Directed toward the achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s).

- **Group Training**

Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of such things as problem solving skills, illness and medication self-management knowledge and skills, and healthy coping mechanisms.

- **Individual Counseling**

A therapeutic intervention or counseling service shown to be successful with identified youth populations, diagnoses, and service needs, provided by a qualified clinician. Techniques employed involve principles, methods, and procedures of counseling that assist the youth in identifying and resolving personal, social, vocational, intrapersonal, interpersonal concerns.

- **Service Plan Development**

Development of the Individualized Recovery/Resiliency Plan based on the results of the Diagnostic and Behavioral health assessments. Plan is required within the first 30 days of service.

- **Community Transition Planning**

Community Transition Planning (CTP) is a service provided by Tier 1, Tier II and IFI providers to address the care, service, and support needs of youth to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual, family, or caregiver with a minimum of one (1) face-to-face contact with the individual prior to release from a facility. Additional Transition Planning activities include: educating the individual, family, and/or caregiver on service options offered by the chosen primary service agency; participating in facility treatment team meetings to develop a transition plan

Specialty Services

- **Intensive Family Intervention**

Services intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification, or preventing the utilization of out-of-home therapeutic venues for the identified youth. Services are delivered utilizing a team approach and are provided primarily to the youth in their living arrangement and within the family

system. This service includes crisis intervention, intensive supporting resources management, resource coordination, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services.

- **Child and Adolescent Structured Residential Supports**

Formerly Rehabilitation Supports for Individuals in Residential Alternatives, Levels 1 & 2, are comprehensive rehabilitative services to aid youth in developing daily living skills, interpersonal skills, and behavior management skills; to enable youth to learn about and manage symptoms; and aggressively improve functioning/behavior due to SED, substance abuse, and/or co-occurring disorders.

- **Crisis Stabilization Units**

This is a medically monitored residential treatment alternative to, or diversion from, inpatient hospitalization, offering short-term psychiatric stabilization and detoxification services.

- **Community Based Inpatient Psychiatric and Substance Detoxification Services**

A short-term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance related disorder.

- **Mobile Crisis**

This service provides time-limited crisis intervention in the community to reduce escalation of a crisis situation, relieve the immediate distress of individuals experiencing a crisis situation, reduce the risk of individuals doing harm to themselves or others, and to promote timely access to appropriate services for those who require ongoing mental health and co-occurring mental health and substance abuse services. This service is available 24 hours per day, seven days per week.

- **Parent Peer Support Service- Group**

This is a strength-based rehabilitative service provided to parents/caregivers in order to promote recovery by increasing the family's capacity to function within their home, school, and community. Services are rendered by a Certified Peer Support-Parent (CPS-P) and uses a group format.

- **Parent Peer Support Service- Individual**

This is a strength-based rehabilitative service provided to parents/caregivers in order to promote recovery by increasing the family's capacity to function within their home, school, and community. Services are rendered by a Certified Peer Support-Parent (CPS-P) and uses an individual format.

- **Youth Peer Support- Individual**

This is a strength-based rehabilitative service provided to youth who are living with a mental health, substance use, and/or co-occurring health condition. This one-to-one service, rendered by a Certified Peer Support-Youth (CPS-Y), models recovery by using lived experience as a tool.

- **Psychiatric Residential Treatment Program (PRTF)**

Psychiatric Residential Treatment Facility (PRTF) services provide comprehensive mental health and substance abuse treatment to children, adolescents, and emerging adults from ages six through twenty-one who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in an inpatient treatment setting and for whom alternative, less restrictive forms of treatment have been tried and found unsuccessful, or are not medically indicated. PRTF programs are designed to offer intensive, focused treatment to promote a successful return of the youth/emerging adult to the community.

- **Intensive Customized Care Coordination**

Intensive customized Care Coordination is a provider-based High-Fidelity Wraparound intervention, as defined by the National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is sought.

- **Clubhouse Services**

Resiliency Support Clubhouse Services for children and youth (ages 6-21) with behavioral health needs has been modeled after its counterpart within addictive diseases. These Resiliency Support Mental Health Clubhouses are designed to provide a comprehensive and unique set of services for children and families coping with the isolation, stigma, and other challenges of mental health disorders.

Services can be provided in schools, child welfare offices, public health offices, juvenile courts, homeless and emergency shelters, youth and family homes, and other community settings defined by the youth and family. Two of the services above that represent treatment approaches that move away from traditional clinic-based services for youth with SED are Intensive Family Intervention (IFI) and Community Support. Youth returning from hospital and residential settings often require higher intensity of services such as IFI. Community Support, which is less intensive than IFI, provides for skill building as well as the essential case management functions of service planning, linking and monitoring to ensure adequacy and continuity of care. These

services are provided to each youth through a service authorization process based on level of need.

For youth between the ages of 6-21 who do not need intensive outpatient services, the DBHDD Office of Children, Young Adults & Families leverages state and MHBG funds to support the Mental Health Resiliency Support Clubhouse program (MH Clubhouse) designed to provide a comprehensive and unique set of services for youth and their families coping with the isolation, stigma and other challenges of mental health disorders. Members and their families participate in clinical sessions, social outings, and career building activities, educational support, and other structured activities designed to support their needs and help them to function better at home, in school, in the community, and throughout life. Fifteen (15) MH clubhouses are geographically located throughout the state.

Community-based Crisis Services

DBHDD has worked, successfully, to move from heavy reliance on acute care hospital services to increased community services. To that end, all state-operated long-term and short-term hospital units were closed some years ago. Comprehensive Community Providers (CCPs) are required to provide crisis services for youth receiving services. In addition, youth in need of acute care, crisis stabilization and treatment are being served through the array of Crisis Stabilization Units (CSUs) and mobile crisis services.

The **Child and Adolescent Crisis Stabilization Unit (CSU)** is a short-term crisis stabilization program for youth with mental health and substance abuse needs. The first community-based CSU was opened in August 2005 utilizing savings from the child and adolescent hospital unit closure at Georgia Regional Hospital Savannah. Four additional CSUs were opened between 2006 and 2009 in Columbus, Rome, Augusta and Atlanta but only one of these programs remain due to underutilization of the programs. The Atlanta program remains open and has 27 beds serving youth ages 14-17. Lakeside CSU in the Savannah area is open and has capacity for 16 beds serving youth ages 5-17. To replace the ones closed and to allow for better geographic access, two CSU's opened in FY10 in Macon and in Greenville, which is in the geographic middle area of the state. The Macon CSU has 16 beds serving youth ages 5-14 and the Greenville CSU has 12 beds serving youth ages 5 – 17. Statewide there are 4 CSUs with a total capacity of 71 beds.

In November 2015 the DBHDD Office of Children, Young Adults and Families entered into contract agreements with nine private in- patient hospitals for **short- term acute crisis stabilization State Contract Beds**. These contract beds provide increased coverage across the state in order to supplement the 71 beds managed by the 4 CSU's. These contract beds are used when CSU beds are unavailable. In addition, youth without insurance or with non- CMO Medicaid are not accepted by a CSU are eligible for review for a State Contract Bed. Also, in

July 2017, three additional private in – patient hospitals were added bringing the total State Contract Bed providers to 12.

Mobile crisis response was funded over a period of time bringing coverage to all 159 counties. Behavioral Health Link, LLC, and Benchmark, Inc. are the providers of mobile crisis services. Georgia's Crisis and Access Line, GCAL, provides continuous access to services for persons in crisis or seeking routine or urgent mental health and/or addictive diseases services via a toll-free phone line. In crisis situations, GCAL connects the person to free-standing mobile crisis services, Crisis Stabilization Units, hospital services, or 911, as applicable to the situation. The call center operates 24/7 and has the capacity to screen and assess callers for intensity of service response. GCAL received over 250,000 calls in FY 17, handled over 160,000 distinct episodes of care and dispatched mobile crisis over 15,000 times of which 3921 dispatches were to youth and their families.

In addition to the need for CSUs, DBHDD identified a need for a Community Intensive Residential Treatment program for juveniles under Superior Court jurisdiction and adjudged as incompetent to stand trial or not guilty by reason of insanity. The program was developed at the end of FY09 to provide psychiatric treatment, competency remediation services, or both for these juveniles who would otherwise be admitted to state hospitals. This secure facility is located in the west central part of the state, has a bed capacity of 14, and typically serves 13-18 year olds. Youth remain there until they return to jail, are transferred to another facility, or discharged to the community.

During FY17, DBHDD developed a contractual agreement with one of the local psychiatric residential treatment facilities (PRTFs) to serve youth ages 12-17 in the juvenile justice system who have been deemed incompetent but restorable. This contract assures that there will be up to six beds available whenever the Department decides, by virtue of a forensic evaluation, that the young person is restorable and can benefit from the appropriate level of care offered by the facility. Once the youth has had the complete assessment to determine the appropriate level of care (up to and including the PRTF level of care), he is enrolled in the program; he also receives competency restoration services from DBHDD's forensics team. The youth will complete the course of treatment and will be referred back to the Juvenile Court upon completion of the competency restoration services.

The state added Psychiatric Rehabilitation Treatment Facility (PRTF) services to the state Medicaid plan in FY08. The PRTF is the highest level of care in the specialty services. There are six PRTFs in Georgia. Youth in parental custody who are under the Medicaid Rehabilitation Option (MRO) coverage, or are uninsured and who are not under Care Management Organization (CMO) Medicaid, are the responsibility of the State, and are reviewed for PRTF eligibility by the State's administrative services organization (ASO), Beacon Health Options, a

member of the Georgia Collaborative. PRTFs serve children and youth ages 6-21 who require an intensive treatment program in an out-of-home setting due to behavioral, emotional, and functional challenges which cannot be safely and sufficiently addressed in the home or community. Referrals to the PRTF level of care made be made by the child's Tier One/core services provider, a crisis stabilization unit (CSU), or another PRTF.

To avoid overuse of the PRTFs, in 2006 Georgia applied for and received a five-year $21 million grant from the Center for Medicare and Medicaid Services. For the grant implementation, Georgia developed a 1915 C Waiver Demonstration Program to develop community-based alternatives to PRTF level of care. With the implementation of the Community Based Alternatives to Psychiatric Residential Treatment Facilities Program (CBAY), DBHDD developed a package of therapeutic and non-therapeutic services for participants to enable them to stay in their home communities and divert them from admission to a PRTF. As part of this implementation, Care Management Entities (CMEs) were created to deliver intensive care coordination and family support utilizing a High-Fidelity Wraparound model of care. The Care Management Entity staff received training in the Wraparound Approach by Innovations Institute from the University of Maryland. Currently, there are two CMEs.

CBAY utilized a systems approach that targeted youth served by multiple agencies, striving to coordinate, blend and braid programs and funding to create a comprehensive behavioral system that ensured youth were placed in and remained in intensive residential treatment only when necessary and that a coordinated system of services at the community level was available. Youth and family that qualified for this waiver, as an addition to the state plan mental health services they were already entitled to, had access to additional services: Care Management, Respite, Supportive Employment Services, Youth Peer Support Services, Family Peer Support Services, Customized Goods and Services, Behavioral Assistance, Community Transition, Consultative Services, Waiver Transportation, and Financial Support Services. In addition, DBHDD provided additional funding to serve youth that did not meet the qualifications for the waiver program, but whose needs were intense enough to need care coordination and family support offered through the CBAY program.

The DBHDD continues to administer a program of high-intensity home and community-based supports for youth who meet PRTF criteria. In the absence of Congress approving PRTFs as an institution for which 1915(c)s can be utilized, the state has continued to continue to provide community services and supports to new youth meeting the level of care for PRTF through the federal Money Follows the Person (MFP) and Balancing Incentive Plan (BIP) to sustain the waiver into a program for youth in PRTFs whose families choose community-based services as an alternative to institutional care. BIP funding ended in 2017, and MFP funding will end in 2020. Although BIP has ended, the program continues to be supported by MFP. In order to achieve greater sustainability for youth who do not meet MFP eligibility, effective 10/1/2017,

Intensive Customized Care Coordination, and Parent and Youth Peer Services, CME services, and associated rates, were added to the State Medicaid Plan and will have rates associated with each service, promoting sustaining access to the services most used by CBAY recipients

CBAY was advised by a CBAY Quality Council and included several family members, DBHDD Office staff, child-serving agency representatives, providers and other selected stakeholders. The CBAY Quality Council continues to meet quarterly, convened by DBHDD's Office of Children, Young Adults and Families, with the following charge: advise on performance and outcome measures to be used in evaluating CBAY services and providers; review information and performance/outcomes data presented and evaluate trends, patterns, systemic issues of concern, as well as positive reports and outcomes of services; and make recommendations on process and service improvements to enhance the program.

To further build on developing these best practice approaches, DBHDD and DCH, Division of Medicaid Assistance, partnered with the states of Wyoming and Maryland along with the National Center for Health Care Strategies (CHCS) to apply for the Centers for Medicare and Medicaid Services Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant to "evaluate promising ideas for improving the quality of children's health care". CHCS, Inc. and the state partners were awarded $10,993,171 over a five-year period to focus on children's behavioral health. The benefits of the partnership would inform other states and CMS about effective approaches and challenges to implementation of the CME provider model. In this work, Georgia focused on:

- evaluating and refining the CME model taking into account best practices nationally,
- evaluating and refining the CME financial model and rate structure,
- evaluating national models of excellence for Care Management
- establishing a continuous quality improvement framework for CMEs
- developing a credentialed network of family and youth peer specialists

The project ended in February 2016 and enabled DBHDD to develop the Certified Peer Support (CPS) training and certification process for both parents and youth with lived experience to provide peer support in Georgia. DBHDD continues to train and certify CPS-Ps (parents) and CPS-Ys (youth). In addition, both parent and youth peer services have been added to the state Medicaid plan to allow providers to bill for peer support services delivered by CPS – P/Y. This will greatly increase consumer access to peer support in Georgia for families and youth experiencing issues with Serious Emotional Disorders (SED).

OCYF Special Initiatives

Over the course of the 2015-2016 academic year, DBHDD's Office of Children, Young Adults, and Families provided grant funding to 29 Tier 1 (i.e. community service boards) and Tier 2 Plus providers to support the integration of community mental health professionals in the learning

environment of targeted schools. This **school-based mental health services program**, known as the Georgia Apex Program, was developed in order to enhance access to the appropriate level of care; to provide early detection of child and adolescent behavioral health needs; and to develop and sustain coordination and collaboration between Georgia's community mental health providers and the school districts in their service areas. From Year 1 to Year 4, the number of schools served by the Apex program grew 220 percent.

In FY15, DBHDD awarded **Transition Age Youth and Young Adult Supplemental Support Funds** (TAYYA-SFF) to six CCP's. These awards of $100,000 each were designed to increase cooperation and collaboration across agencies to meet the needs of TAYYA with serious mental health conditions and their families. These monies further the work of building infrastructure for non-billable time related to enhance outreach and engagement to emerging adults and build youth leadership/advocacy skills that is not reimbursable through Medicaid or other funds. They support best practices, cultural competence, support services that assist youth with independent living address needs for housing, employment, education, basic living skills, and social support not supported by other funding. The expected outcomes were to improved access to services, effective services to assist with transitioning into adulthood and enhanced linkages and coordination of a non-clinical nature.

In FY 2016, a new Statement of Need (SON) was developed for **Emerging Adult Support Services** that was specific to the unique needs of the population and required goals to be achieved for individuals engaging in the grant. As a result of the new SON there were 11 grantees awarded $100,000 and through technical assistance was able to restructure programming to increase a seamless transition for young adults.

Emerging Adult Support Services (EASS) is designed to create developmentally-appropriate and effective youth-guided local systems of care to improve outcomes for emerging adults with serious mental health conditions in areas such as education, employment, housing, mental health, and co-occurring disorders, and decrease contacts with the criminal justice system. OCYF supports EASS grants to Comprehensive Community Providers and "Not for Profit" providers to meet the following objectives: 1) Increase and improve cooperation and collaboration across agencies to meet the multiple and complex needs of emerging adults with serious mental health conditions and their families; 2) Enhance outreach and engagement to emerging adults and build youth leadership/advocacy skills; 3) demonstrate improving access and expanding the array of community-based, age-appropriate treatment, culturally and linguistically competent services and supports for emerging adults as well as their families. Each grantee has a unique referral process as well as programming, therefore it is recommended that an individual contact each respective organization for more information. In FY18, EASS merged into OCYF's state funded system of care programming.

In partnership with the Office of Federal Grant Programs and Cultural and Linguistic Competency, the OCYF is supporting implementation of the Listening, Inspiring, and Guiding Healthy Transitions, Early Treatment Program for First Episode Psychosis (LIGHT-ETP). The LIGHT-ETP provides Coordinated Specialty Care for young adults ages 16-30 who have recently begun experiencing symptoms of severe mental illness, specifically first-episode psychosis. The goals of LIGHT-ETP include early detection of psychosis; rapid access to coordinated, team-based, multi-element specialty care; evidence-based, recovery-focused interventions; and youth- and young-adult-friendly services that emphasize engagement, assertive outreach, and person-centered planning. The intended outcomes include a reduction in the duration of untreated symptoms and illness; reduction in unnecessary hospitalizations; and improved clinical, social, and academic/occupational functioning. The services offered by the multi-disciplinary LIGHT-ETP teams include psychotherapy, case management, supported education & employment, peer support, family support and education, and medication management, and /primary care coordination. More information on this program is in the Environmental Factors section of this plan.

DBHDD has also provided funding support to providers of child and adolescent mental health services for purposes of supporting activities that build on system of care infrastructure and support in local communities. In FY15 ($1.4M) and continued into FY16, DBHDD awarded **System of Care Enhancement and Expansion Funds (SOC-EEF)** to 15 Child and Adolescent Mental Health providers throughout the state. These awards, under contract, are used to support system of care value oriented in child and adolescent mental health. These monies further the work of building infrastructure for non-billable time related to family team meetings, LIPT meetings, and other consultative services with the other child serving agencies that are not reimbursable through Medicaid or other funds. They support best practices, cultural competence, training, outreach activities to engage families, Non-Medicaid, non-billable transportation to and from treatment related activities, snacks for consumers during groups and programming, community education activities on system of care work, and engagement activities with youth not supported by other funding. The expected outcomes are improved family access to services, and. enhanced linkages and coordination of a non-clinical nature. In FY18, EASS became one of the deliverables of SOC-EE.

OCYF has established **community innovation pilots/grants** to support existing or new behavioral health services, programs, or projects that assist OCYF with accomplishing its mission and add value to Georgia's public mental health system serving children, young adults and families. These organizations work within the System of Care (SOC) framework, to include values such as collaboration, strength-based, cultural competence, and family/youth voice/choice.

DBHDD received funding beginning in FY 2018 to implement a very limited crisis benefit for Autism Spectrum Disorders. The DBHDD Office of Medicaid Coordination is spearheading a collaborative project between the Division of Behavioral Health and the Division of Intellectual/Developmental Disabilities to implement an ASD Crisis Stabilization Unit (10 beds) as well as 2 ASD Crisis Support Homes (3 beds each). DBHDD, in its 2019 implementation of a new Mobile Crisis procurement, added ASD competency to the Mobile Crisis response expectations.

Substance Abuse Treatment and Prevention Services

Substance Abuse Treatment

The **Office of Addictive Diseases (OAD)** provides Core and Specialty Services. In addition, OAD continues to increase the array of treatment services available for youth with substance abuse issues. The services are: intensive residential treatment programs (IRTs) and the clubhouse recovery support services for youth. In addition, DBHDD funds two Adolescent Intensive Residential Treatment (IRT) Programs. The IRTs provide 24-hour supervised residential treatment for adolescents ages 13-17 who need a structured residence due to substance use disorders. The programs are located in the metropolitan Atlanta and in the southern part of the state. Currently there are fifty IRT beds for adolescent addictive disease treatment, fifteen beds allotted for females and the remaining beds for males. These two treatment centers have historically served youth that have both substance use disorders and SED related issues and are often used as a referral source by the juvenile court system.

The Clubhouse model, which is a recovery support services model combined with an evidence-based program for helping Georgia youth with substance use issues, was started by OAD in 2008 to create a safe and stable environment for youth. The clubhouse is a unique comprehensive substance abuse recovery support model that engages adolescents and their families to look at, and make changes in their lives in order to maintain a healthy and sober lifestyle. The model offers a unique way to engage and retain youth in services. The Clubhouse is a supportive environment where the youth are members. Staff and members work together to perform the tasks of the clubhouse and participate in social outings, educational supports, employment supports, nutrition education and other specific clubhouse activities.

There are nine substance use recovery support clubhouse programs throughout the state of Georgia providing services to youth with a primary substance use diagnosis including one clubhouse program providing services to youth with co-occurring issues. Additionally, one of the clubhouse programs provides recovery support services that focus on the needs of the Latino population.

Prevention Services and Programs

The **Office of Behavioral Health Prevention (OBHP)** supports the health and well-being of individuals, families and communities by reducing the use and abuse of substances and their related consequences across the lifespan, and delaying the onset of substance use by youth using a data-driven planning process that targets high priorities for all categories of the population defined by the Institute of Medicine.

In February of 2015, OBHP re-organized to reflect some of these common linkages and shared risk and protective factors with Substance Abuse and Suicide Prevention, and Mental Health Promotion. OBHP utilizes a public health approach (population based) and the Strategic Prevention Framework Model (Assessment, Capacity, Planning, Implementation and Evaluation). OBHP's infrastructure is set up as the Georgia Strategic Prevention System (GASPS). OBHP operates as the central decision-making authority that executes services through a community contracted providers, partners, and community coalitions. Planning and operations are conducted with input and collaboration of a Community Advisory Council (CAC) and State Epidemiological Outcomes Workgroup (SEOW). The CAC includes Community Representatives, Key Informers, and Beta Testers. The SEOW includes data stakeholder Agencies' Epidemiologist, Statisticians, Data Coordinators, Evaluators, Agency Directors, and representatives (representing organizations such as Dept. Of Education, Public Health, GA Corner's Association, Medical Association of Georgia, Georgia Drugs and Narcotics Agency, and others).

Currently there are 16 projects under the Substance Abuse Prevention segment of OBHP. They include: Alcohol & Substance Abuse Prevention Project (ASAPP), 3 Prevention Clubhouses, A Governor's Red Ribbon Campaign, SYNAR Tobacco Compliance (with GA DOR), GA Prescription Drug Abuse Prevention Collaborative (GADAPC), Drugs Don't Work Program, Partnerships For Success II (GenRx) Prescription Drug, Maternal Substance Abuse (MSA) Child Development Project, Georgia Teen Institute, Voices For Prevention (V4P), and GASPS Data Warehouse Project, and under the Targeted Response to the Opioid Crisis Grant there is a Statewide Media Campaign for addressing Opioid Misuse and Abuse, Four SPF Opioid Pilot Projects, a School Transition Mentor Pilot Project, and a Naloxone Education and Training Program.

Substance Abuse Prevention Projects: The **ASAPP Project** is a statewide initiative aimed at preventing alcohol and identified substances of abuse and promoting healthy lifestyles and choices among Georgians. Based on epidemiological data early onset of alcohol use and abuse and binge drinking have been identified as major public health and safety issues in Georgia. The objective of ASAPP is to implement evidence-based prevention strategies (programs/practices/policies) targeting the state's identified priority need, Alcohol and to allow communities to address a second local priority need identified using local data. The project

requires all providers to participate in a state level evaluate and all providers to conduct and share results of their local community evaluation. This is based on a Strategic Prevention Model (SPF) and a public health approach to determine effectiveness of strategies for different communities for producing and sustaining successful outcomes and allow OBHP to use data to drive future prevention decisions and efforts. The following are the State's Primary goals around Alcohol:

1) Reduce the early onset of alcohol use among 9-20 year olds
2) Reduce access to alcohol and binge drinking among 9-20 year olds
3) Reduce binge drinking and heavy drinking among 18-25 year olds

Providers are also required to join with community coalitions and developed Community Prevention Alliance Workgroups (CPAW) to effectively implement the strategies and garner community buy-in for accomplishing the goals.

OBHP believes this approach will result in and centers on communities developing and implementing sustainable outcome-based prevention strategies.
https://dbhdd.georgia.gov/alcohol-prevention-project-0

The Drugs Don't Work Program is designed to help employers become certified drug-free workplaces by establishing employee assistance programs and drug-free workplace policies.
http://dbhdd.georgia.gov/drugs-dont-work-georgia

The **HODAC Helpline** is a confidential first step for families, friends, employers or the addicted individual. Trained, caring telephone information specialists are available 24-hours a day, seven days a week to provide information about addictive disease, alcohol and other drugs; treatment options; locations of treatment facilities and self-help organizations, DUI Risk Reduction programs, drug laws, etc.
http://www.hodac.org/

The Georgia Prescription Drug Abuse Prevention Collaborative (GADAPC) focuses on four priority areas to prevent and reduce prescription drug abuse in Georgia. The four areas addressed are those that have been identified by the Office of National Drug Control Policy: education, monitoring, proper medication disposal, and enforcement. It is composed of public and private sectors, to work collectively in Georgia to address the priority areas listed above.

The Generation Rx (GEN Rx) Project is a response to the growing epidemic of prescription drug abuse among youth and young adults in Georgia. The objective of GEN Rx is to implement evidence-based strategies to reduce prescription abuse among 12 – 25 year olds within the targeted areas of Catoosa, Early and Gwinnett counties. The project is funded by the OBHP/

DBHDD through a Federal SAMHSA (Substance Abuse and Mental Health Services Administration) grant.

Strategies:
The primary strategies implemented by the GEN Rx project are Education, Proper Medication Disposal, and Enforcement. Education: Educate Georgia's parents, youth, the general public, physicians, pharmacists, elderly adults and their caregivers, etc. about the dangers of prescription drug abuse and the appropriate use, proper storage and safe disposal of prescription drugs. Proper Medication Disposal: Encourage convenient, environmentally responsible and safe prescription drug disposal programs to decrease the supply of unused prescription drugs in the home. Enforcement: Collaborate with law enforcement to eliminate improper prescribing practices as well as prevention "pill mills", "doctor shoppers", and other similar drug-seeking behavior.
http://genrx.us/

The Georgia Strategic Prevention System (GASPS) Data Warehouse is an innovative response to Georgia's need for evidence-driven, outcome-based substance abuse prevention. The GASPS warehouse is an online repository containing a wealth of information on substance abuse, its consequences, and related social indicators. The GASPS data warehouse is created using interactive and innovative data visualization software called Tableau Public, which is fully integrated with social media platforms, allows users to interact and customize their data experience, and creates visually stunning charts, graphs and maps that will update in real time on our providers' websites. County-level data in our warehouse includes student health surveys, substance abuse-related arrests, traffic morbidity and mortality, vital records information, child wellness indicators, and substance abuse treatment admissions. The online site has been developed by the OBHP through a contract with the University of Georgia, Carl Vincent Institute.
www.gaspsdata.net

The Georgia Teen Institute is a youth leadership program for Youth Action Teams throughout Georgia that begins with a summer training program and continues with year-round support. Youth teams attend a four-day residential camp held at Oxford College to develop leadership skills and engage in the Strategic Prevention Framework planning process through workshops, team meetings, and team building activities. The teams work to plan and implement peer-focused substance abuse prevention and community service projects. GUIDE follows up throughout the year with additional training and technical assistance, networking meetings and monthly reports outlining teams' actions and activities.
http://guideinc.org/what-we-do/georgia-teen-institute/

Maternal Substance Abuse and Child Development Project (MSACD) is committed to raising the awareness of the devastating effects of alcohol and other substances when used during pregnancy. MSACD collaborates with Georgia's Alcohol Prevention Providers and their communities in all six of Georgia's regions to raise awareness about alcohol and substance abuse among pregnant women. MSACD has currently established relationships with at least one community in every region across the state. Collaborations have included media messages on maternal substance abuse during pregnancy and supplying resources addressing the use of any substance. Trainings on maternal substance abuse, child development, alcohol and other drug related effects are conducted for prevention providers. MSACD also presents at and participates in state prevention conferences such as the Georgia School of Addiction Studies and the Summit on Youth Issues.
http://www.emory.edu/msacd/

The Minimum Data Set Version 2.0 (MDS) is OBHP's online reporting system for the capture of block grant prevention process service data across the state. The MDS system enables OBPH to quantify and compare the numbers and types of primary substance abuse prevention and early intervention services delivered throughout the state of Georgia. This data is also utilized in reporting Block Grant data to SAMHSA.
https://www.geprgoa,ds/uga.edu

The OBHP funds three very innovative and unique **Prevention Clubhouses** that were designed to provide prevention services to high risk youth ages 12-17 to address socio-economic ills and risk factors they face in their communities at home. They are located in Norcross, LaGrange and Dawson, Georgia. Each Prevention clubhouse is unique and diverse serving the population in that immediate community. Participation is limited to youth who are at high risk for alcohol and drug abuse, involved in ongoing detention and/or alternative school, parent(s) have current or past addiction, sibling(s) currently receiving treatment for substance abuse disorder or experiencing education or social issues.

The clubhouses use peer mentors, evidence-based prevention curriculums, and interactive engaging youth activities to build coping, decision making, and life skills. They each include family activities/participation, community service, education and employment services, nutrition, physical activities and an evidence-based prevention curriculum. The clubhouses provide a safe, comfortable and exciting place for the youth they serve.
https://dbhdd.georgia.gov/prevention-clubhouses

The **Red Ribbon Campaign** is a media and activity driven strategy aimed at building general population (universal) awareness of the importance of a drug free lifestyle. Each year, schools and communities are encouraged to develop messages and activities to demonstrate their commitment to living drug-free lifestyles in a competition for prizes.

SYNAR compliance is contracted with the Georgia Department of Revenue. In July 1992, congress enacted the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (P.L 102-321), which included the Synar Amendment (named for its sponsor, Congressman Mike Synar of Oklahoma

- The goal of the Synar Amendment is to reduce the number of successful illegal tobacco purchases by minors to no more than 20 percent of attempted buys
- Amendment calling for state to enact and enforce laws preventing the sale of tobacco products to minors.
- Require conducts of an annual coverage study
- Requirement of the SAPT BG
- Georgia's 2010 (2009 investigations) Synar non-compliance rate+ 9.8%

The SYNAR amendment requires states to have laws in place prohibiting the sale and distribution of tobacco products to persons under the age of 18 and to enforce those laws effectively. OBHP contracts with GA DOR to conduct retailer tobacco compliance checks across the state.
http://georgia.gov/agencies/georgia-department-revenue

The mission of **Voices for Prevention (V4P)** is to build a unified statewide voice for substance abuse prevention by collaborating with a diverse group of prevention specialists, service providers, community coalition members and individuals with an interest in and a commitment to substance abuse prevention. This mission will be accomplished by advocating and educating on substance abuse and related issues.
http://v4pga.org/about-us/

The Georgia State Targeted Response to the Opioid Crisis (STR Opioid) Project is a SAMHSA grant for developing a targeted response to the opioid crisis, in Georgia, through prevention, treatment, and recovery initiatives. Prevention programs consist of 4 components. 1) A Statewide Media Campaign to increase awareness about opioid misuse and abuse, provide education about the problem and available resources, reduce stigma, and increase awareness and understanding of the Good Samaritan Law. 2) A Naloxone Education and Training component will provide Naloxone/NARCAN training for first responders and people in the community (ambulance drivers, emergency room professionals, fire fighters, police officers, community service boards, etc.). 3) A School Transition Mentor Program will develop an opioid prevention education program & tool kit for use across key transitional periods. 4) Lastly, a SPF Pilot Program will increase the number of SPF prescription drug prevention providers in Georgia, with an opioid focus.

Suicide Prevention: Current there are 4 projects under the Suicide Prevention segment of OBHP. They are: Community and Agency Suicide Education & Training Project, Training and Technical Support of House Bill 198 (Jason Flatt Act), Promotion and Support of DBHDD's Policy 01-118, Maintaining the Georgia Suicide Prevention Information Network (GSPIN), and implementation of the Garrett Lee Smith Youth Suicide Prevention Grant.

The newly added Mental Health Promotion segment of OBHP is currently under Strategic Planning for incorporation throughout OBHP's work. A "Spot the Signs" Media Campaign to raise awareness, reduce stigma, and improve communications for appropriate referrals is underway.

The current DBHDD/OBHP suicide prevention effort is staffed with the state Suicide Prevention Program Coordinator, a Suicide Prevention Specialist, and a Garrett Lee Smith Coordinator. Georgia received its third SAMHSA Garrett Lee Smith Youth Suicide Prevention Grant in September 2015. The federal Garrett Lee Smith Youth Suicide Prevention (GLS) Program focuses on developing comprehensive suicide prevention programs within schools.

The first GLS grant program included gatekeeper training for school staff and developing protocols and referrals for getting young people at risk of suicide to help as well as training schools in best practices in intervention and postvention. It also included an innovative youth peer support model, Sources of Strength, which was introduced to school systems that had a suicide rate higher than the national average. Through the project, over 850 Adults were trained as gatekeepers and over 600 youth were trained as peer leaders. Twenty-two thousand students were exposed to positive messaging activities and named over 1000 trusted adults in their schools and communities.

The second GLS YSP Grant, focused on serving 15 counties, 16 targeted school systems and 39 schools. A comprehensive Suicide Prevention Program was developed that included: Suicide Prevention Protocols, QPR training for 85% of the staff, Lifelines Training - Intervention and Postvention, an enhanced Gatekeeper Sources of Strength Program, Sustainability Plans, Early Identification and Referrals, networking with local Suicide Prevention Coalitions to create linkages of sustainability, and, promotion of the Georgia Crisis and Access Crisis Line and National Lifeline in English and Spanish. Through contracts with nonprofit organizations and Mental Health provider's specific populations were targeted: CETPA served the Latino population in Gwinnett County; the Community Service Board of Middle Georgia served rural populations; the Southern Jewish Resource Network, Inc. (SOJOURN) served the LGBTQ community by providing awareness workshops to the community; clergy; and, the Suicide Prevention Coalitions statewide. There was also a contract developed with Camden Community Alliance & Resources, Inc. to help reach military families and their children. Through all the above projects, over 3,000 adults were trained as gatekeepers and over 1,600 youth trained as

peer leaders. 33,330 students were exposed to positive messaging activities and named over 5,000 trusted adults in their schools and communities.

Through this grant, DBHDD/OBHP also implemented the Sources of Strength Program at 6 universities: Ft. Valley State University, Savannah State University, University of West Georgia, Savannah College of Art and Design Savannah and Atlanta Campuses and Georgia Highlands College. Two of those were Historically Black Colleges and Universities (HCBUs). With the guidance of the Sources of Strength Team the Sources of Strength curriculum was adopted for colleges/universities students and a University Program Manual was created. The Sources of Strength developer and the GLS project director provided on-site technical support and training to the Sources of Strength Teams at each campus each year. The Sources of Strength Team at each university also developed a series of activities focusing primary on suicide prevention and wellness impacting many areas creating collaboration with several organizations, associations, programs within their campuses.

The GLS YSP grant program also co-sponsored the Suicide Prevention College Conference the 4th year. The purpose of the conference was to introduce colleges to suicide prevention as a public health issue and exchange ideas on working with special populations, engaging stakeholders, developing policy, screening, use of evidenced based practices in prevention; developing coalitions, stigma reduction, Sources of Strength peer program, and gatekeeper training. Two hundred and seven individuals attended representing 37 colleges/universities. In addition, the project partnered with 25 organizations.

The project also offered a comprehensive training package that included: QPR gatekeeper training; Annual Professional Seminar Series on Critical Issues Facing At-Risk Children; Assessing and Managing Suicide Risk; Counseling on Access to Lethal Means; Working with Those Bereaved by Suicide in the Professional Setting: Postvention Strategies; Mental Health First Aid; and suicide prevention toolkits for primary care physicians impacting over a 1,000 professionals annually in communities throughout the state and delivered 75 Suicide Prevention Toolkits for Rural Primary Care and Pediatric and Family Care.

The most current GLS grant, the *Georgia Suicide Safer Communities for Youth Project* focuses on youth ages 10 to 24 years living in three Georgia counties (Bartow, Newton and Oconee) with youth suicide death rates higher than the national average of 8.02 for the years from 2011 - 2013. Selected populations of focus include African American youth, youth suicide attempters, and family members of youth who have been identified with suicidal ideation or a suicide attempt. Community assessments in each county helps identify county specific populations of focus. It is estimated that 1,000 will be served annually and 5,000 over the life of the 5-year project.

We are currently in Year 2 of the 5-year project. Through our work in the first two years, we have identified the need for youth suicide prevention efforts in the surrounding areas of the counties that were originally identified with high youth suicide death rates. Because of the youth suicide deaths in the surrounding areas, the GLS grant will expand to meet the needs of youth suicide within the whole agencies involved in the project starting Year 3. Those three sub-grantees are Advantage Behavioral Health, Highland Rivers Health and View Point Health. The *Suicide Safer Communities* project is guided by 5 of the 13 National Strategy for Suicide Prevention goals and their objectives, including: Goal 1: Develop, implement, and monitor effective programs that promote wellness and prevent suicide related behaviors. Goal 2: Provide training to 3,500 community and clinical service providers on prevention of suicide and related behaviors. Goal 3: Promote suicide prevention as a core component of health care services. Goal 4: Promote and implement effective clinical and professional practices for assessing and treating 1,500 youth identified as being at risk for suicidal behaviors. Goal 5: Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

As a part of larger funding issued to The Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD) through the Garrett Lee Smith federal funding from September 2015 through September 2020, The College and University Coalition, made up of over 30 institutions of higher education including technical schools and public and private colleges and universities, is included in the Georgia Suicide Safer Communities for Youth Project.

Under this project, The Georgia College and University Suicide Prevention Coalition will provide a yearly Suicide Prevention Conference for Colleges and Universities, three additional suicide prevention training opportunities a year and assessment, data collection, tracking and evaluation services for the College Coalition. The Georgia College Suicide Prevention Coalition (College Coalition) will oversee targeted college and post-secondary education efforts. The efforts of Georgia's colleges and universities are included in the GLS goals to serve 5,000 youth and their families over the life of the 5-year project.

Mental Health Prevention Projects: OBHP is developing plans for incorporating Mental Health Promotion throughout OBHP work. OBHP is developing a "Spot the Signs" PSA to raise awareness, reduce stigma, and improve communications for appropriate referrals.

Criterion III: Children's Services: System of Integrated Services

Georgia does not have one agency responsible for all children's services. There are eight state agencies responsible for service delivery to children and their families. All agencies must work together to provide a system of care for children and youth with SED. DBHDD is only

responsible for provision of services to youth and their families requiring public behavioral health services who are uninsured, receiving adoptive services or disabled. The Department of Community Health (DCH) is responsible for behavioral health services to youth and their families who are Medicaid eligible due to poverty, in the custody of child welfare or committed to the DJJ. The Department of Human Services (DHS) is responsible for child welfare and regulatory services for residential child caring institutions. The Department of Juvenile Justice is responsible for probation, detention services and residential services for youth involved with juvenile justice. The Department of Public Health is responsible for county-based health services and early intervention services. The Department of Education is responsible for education services provided under IDEA to youth with SED. The Georgia Vocational Rehabilitation Services Agency is responsible for transition services for youth age 14-21. The Department of Early Care and Learning (DECAL) is responsible for Head Start Programs and other services to children 0-3 years old. The services provided by the primary child-serving agencies are discussed below.

Child Welfare

The Division of Children and Family Services (DFCS) under DHS provides Prevention, Safety (child protective services), Permanency (foster care, adoption, and kinship), and Well-Being (education, physical and mental health, and youth development) Services. Most of the children receiving these services have experienced the trauma of neglect or physical, emotional or sexual abuse; and a significant portion of them are youth with severe emotional disorders (SED). DFCS provides mental health services to youth with SED through referrals to DBHDD providers or to the private sector. In addition, some foster care funds are used for the Preventing Unnecessary Placement (PUP) Program, and can be used to purchase alternative Support and In-home services to prevent the need for removal of children from their homes. DFCS also works with community-based agencies providing a variety of services to children and families through the Promoting Safe and Stable Families (PSSF) Grant. This Program provides funding for the purchase of family support, family preservation, time-limited reunification services and adoption promotion and support services to ensure the safety, permanency and well-being of children. Another program, Intensive Community Support Program (ICSP) enables DFCS, foster caregivers, and community partners to think outside of mainstream therapeutic services which could assist a child in maintaining stability in a home, transitioning out of a more restrictive setting like a Psychiatric Residential Treatment Facility (PRTF), or reunifying with family.

DFCS also provides for a comprehensive assessment of youth entering foster care through the Comprehensive Child and Family Assessment (CCFA)process. This process focuses on early and continuous assessment of the strengths and barriers faced by children and their families, case plan development with the family and the use of a full continuum of services that best meets the unique needs of children in the least restrictive setting possible. A recent change to the mental health component of the CCFA is the replacement of a full-scale psychological evaluation with a

trauma assessment within the first 25 days of coming into foster care. It is known that the reasons that children are removed from family are based on neglect and abuse, however in addition they must cope with a change in their home environment, school environment and everything that is known to them. Having a psychological evaluation completed so soon after removal may not yield results that are true to the needs of that child. The purpose of the trauma assessment is to instead identify the experiences that that each child has had which may be considered traumatic or stressful and how he or she is functioning. If additional mental health assessments are required, then they are provided as well. DFCS continues to seek community-based services available to address the behavioral health needs of children and youth in care. Partnerships with state and community level providers supports the need for workforce development and research and training in evidence-based modalities.

Juvenile Justice

The Department of Juvenile Justice (DJJ) provides services to emotionally disturbed youth offenders and their families. Every youth confined in a secure facility is screened for possible mental health problems, trauma, substance abuse problems and suicide risk. If screening does suggest a need for mental health services or suicide precautions, the youth is referred for a mental health assessment. Every youth committed to DJJ and placed in a secure long-term secure facility receives a mental health assessment by a qualified mental health provider within ten days of admission. Youth who are assessed and determined to need mental health services are then treated in accordance with a treatment plan developed by a multidisciplinary treatment team.

The DJJ Office of Behavioral Health Services is responsible for mental health services for youth detained in any of the agency's short-term Regional Youth Detention Centers (RYDCs) and long-term Youth Development Campuses (YDCs). Georgia DJJ currently operates 19 RYDCs and 7 YDCs.

Youth committed to DJJ are also served in non-secure settings. DJJ purchases residential placements from providers who offer RBWO and utilizes DBHDD state funded and MRO providers of behavioral health services when youth who are not enrolled in the Medicaid Managed Care Program. DJJ also accesses PRTF services for committed youth or DJJ involved youth as needed.

Education

The Georgia DOE ensures that all eligible children with disabilities have available to them a free and appropriate public education (FAPE) that emphasizes special education and related services designed to meet their unique needs. A child may be determined eligible for special education services for autism spectrum disorder, deaf-blind, deaf/hard of hearing, emotional and behavioral disorder, intellectual disability, orthopedic impairment, other health impairment, significant

developmental delay, specific learning disability, speech-language impairment, traumatic brain injury or visual impairment.

Special education is specially designed instruction provided at no cost to parents and may include instruction in the classroom, in the home, in hospitals, institutions and other settings. Instruction may include academic instruction, physical education, travel training, vocational education and related services. Related services are services such as transportation and developmental, corrective, and other supportive services as are required to assist a child with a disability to fully benefit from special education.

An Individualized Education Program (IEP) is developed by an IEP Team for each student receiving special education services. The IEP Team includes the parents of the child, at least one regular education teacher, at least one special education teacher and a representative of the Local Education Agency (LEA) and may include an individual who can interpret instructional implications of evaluation results, other individuals who have knowledge or special expertise regarding the child and whenever appropriate, the child with a disability. The IEP documents the child's present levels of academic achievement and functional performance, measurable annual goals and a statement of the special education and related services and supplementary aids and services to be provided to the child. The IEP must be in effect at the beginning of each school year and must be reviewed periodically, but not less than annually to determine whether the annual goals for the child are being achieved.

Supporting the 186 school systems in Georgia, the Georgia Network for Educational and Therapeutic Support (GNETS) provides comprehensive special education and therapeutic support for the children served. The purpose of the GNETS is to prevent children from requiring residential or other more restrictive placements by offering comprehensive services in local areas. Twenty-four GNETS programs may serve children ages 3 through 21 years in GNETS classrooms, with direct therapeutic services, evaluation and assessment or other services as appropriate. An IEP Team may consider in-class services by a GNETS program for a child with an emotional and behavioral disorder based upon documentation of the severity of the duration, frequency and intensity of one or more of the characteristics of the disability category of emotional and behavioral disorders (EBD).

Since 2008, GA DOE has been an active Positive Behavior Intervention Supports (PBIS) state as recognized by the national Technical Assistance Center on PBIS. PBIS is an evidence-based approach that provides schools with a framework for implementing effective prevention and intervention strategies. The goal at the GA DOE is to support high fidelity implementation of PBIS in schools across the state. The GA DOE PBIS team facilitates district-level planning and provides school team training, technical assistance and ongoing coaching to district coordinators in order to build capacity and support the PBIS process. The types of schools trained have been

Elementary (54%), Middle (23%), High School (13%), Juvenile Justice School and Alternative Schools (11%). Almost 400 school teams have been trained. The GA DOE recently convened a meeting of key stakeholders to inform the development of a state plan for proactively addressing climate, safety, and discipline in Georgia schools through utilization of PBIS. The Director of the DBHDD Division of Behavioral Health and of Children, Young Adults and Families participated in this two-day meeting. With support from state leadership, GA DOE hopes that resources and strengths will be aligned and coordinated to develop next steps to make PBIS available to all Georgia schools.

Georgia Project AWARE (GPA), funded by the Substance Abuse and Mental Health Services Administration, is designed to make schools safer and increase access to mental health services for children and youth. The GPA grant provides the structures and training resources needed to provide mental health services to underserved students in three local school districts: Griffin-Spalding County Schools, Muscogee County Schools, Newton County Schools. GPA is working to provide school-based and community-based resources to support students and families with mental health needs. Both the State and the participating school districts have made an excellent start in addressing the mental health needs of children, youth, families and caregivers. The multiple components of the project including universal mental health screenings, a mental health referral process, Youth Mental Health First Aid (YMHFA) and school-based mental health services. GPA provides local communities with increased access to school and community-based mental health services. The three school districts have made important gains in their efforts to increase awareness of mental health problems and strategies that can help to prevent such problems in the three communities associated with these three school districts and throughout the state of Georgia. GPA has worked collaboratively with DBHDD's Apex project and trained together on the Interconnected Systems Framework (ISF), an integration of mental health into the Positive Behavioral Interventions and Supports framework.

YMHFA trains school personnel, emergency first responders, and other adults who interact with school-aged youth to detect and respond to mental illness in children, youth, and young adults, including how to encourage adolescents and families experiencing these problems to seek and obtain treatment. This program will sunset in September 2019.

Vocational Rehabilitation

The Vocational Rehabilitation Program within the Georgia Vocational Rehabilitation Agency collaborates with DBHDD to provide evaluation, training, and other individualized services that are needed to help consumers obtain and maintain employment. VR staff exchange referrals with mental health provider staff and help link consumers with education, job training, and employment opportunities. Additionally, VR effectively works with schools and other agencies to assist students with disabilities who are transitioning from high school to post-school activities to include employment through the provision of coordinated services such as guidance and

counseling, training and job placement. Furthermore, VR has committed to assist with planning for older youth in residential settings who need training and employment.
VR continues to investigate best practices in removing systemic barriers, through partnerships with DBHDD, and other agencies interested in quality employment outcomes.

Public Health
The Georgia Department of Public Health (DPH) provides services through 18 administrative public health districts and local health departments in all 159 counties. DPH's main functions include: Health Promotion and Disease Prevention, Maternal and Child Health, Infectious Disease and Immunization, Environmental Health, Epidemiology, Emergency Preparedness and Response, Emergency Medical Services, Pharmacy, Nursing, Volunteer Health Care, the Office of Health Equity, Vital Records, and the State Public Health Laboratory.

A close relationship exists in most areas between local public physical health and mental health services. Referrals from behavioral health centers to county health departments are common, especially for routine health/developmental screening and immunizations. Older youth with multiple needs are served through Public Health's Children's Medical Services Program. Younger children at risk of emotional disturbance served through the Babies Can't Wait (BCW) Program, Georgia's Part C Program. Georgia continues to promote programs to encourage Early Periodic Screening Diagnosis and Treatment screenings in Georgia.

The DPH State Office includes the Division of Health Promotion's Maternal and Child Health Section (MCH), which is responsible for the Title V Block Grant. The Title V toll-free hotline, PowerLine, assists parents, health care providers, social service agencies, community organizations, and any other individual or agency experiencing difficulties in obtaining information about health care and/or health care services. PowerLine provides referrals for Babies Can't Wait (BCW), PeachCare for Kids, and Children 1st and maintains Georgia's most comprehensive database of physicians and clinics that accept Medicaid and PeachCare, reduced fees, and/or low-cost fees.

Children 1st is the "single point of entry" to a statewide collaborative system of public health and other prevention-based programs and services. Through a systematic process, children are identified, their risk factors are screened, and children with sufficient biological, social, and/or emotional risk factors are linked to appropriate public health programs and community-based resources. Children who do not present risk factors severe enough to qualify for an early intervention program remain in Children 1st where they are linked directly to a medical home and monitored to ensure that if sufficient risk factors do arise, the identification, screening, and placement in an early intervention program can occur as quickly as possible. Children 1st refers families to other public health programs as appropriate, including BCW and Children's Medical Services (CMS). Linkages are made to Medicaid and PeachCare for Kids as appropriate.

Under the MCH Office of Child Health, the Children and Youth with Special Healthcare Needs' (CYSHN) focus is to provide program development, leadership, guidance, and resources to Georgia's 18 Health Districts in the development and provision of a comprehensive, integrated, and coordinated system of services for children and youth with special needs, birth to age 21 and their families. CYSHN includes Early Intervention Services (Babies Can't Wait) and Children's Medical Services (CMS).

Babies Can't Wait (BCW) is Georgia's statewide interagency service delivery system for infants and toddlers with developmental delays or disabilities and their families. BCW supports a toll-free number for individuals with disabilities, families of children with special needs, and professionals that provides a special needs database/directory of over 5,000 public and private early intervention services, research and demonstration projects, professional groups, parent support groups and advocate associations available in the state for children with or at risk for developmental delays or disabilities. In addition to obtaining information about services, hotline callers can be matched with supporting parents whose children have similar disabilities. The DPH BCW team also collaborates with the DCH and DBHDD in the development of newly-funded ASD services and supports, serving as collaborative subject matter experts to one another as each implements aspects of the Georgia plan for youth ASD services.

The purpose of Children's Medical Services (CMS) is to ensure that there is a community-based, coordinated, family focused, culturally appropriate, comprehensive system of quality specialty health care services available for Georgia's children with chronic medical conditions from birth to 21 years of age and live in low-income households. CMS provides care coordination, specialty medical evaluations and treatment for eligible children and youth who have complex medical conditions. Core CMS services include care coordination with a comprehensive plan of care, assurance that a child has a medical home with a primary care provider, and transition planning for youth ages 16 to 21 years of age.

DPH also provides for dental services for children and youth. The public health dentists and dental hygienists serve children with Medicaid/PeachCare for Kids; low income, uninsured children in need of oral health care; and special needs children. The Oral Health Program has 18 districts throughout the state with some type of school-based or school-linked oral disease prevention program. Referrals to dental providers serving populations with advanced special health care needs are available from the dental public health providers and the State Oral Health Program. The Oral Health Program has developed a statewide referral database for children with special needs.

DPH's Division of Health Protection includes the Chronic Disease Prevention Section which is

responsible for implementing population-based programs and services focused on chronic disease prevention and promoting healthy behaviors and includes the Office of HIV/AIDS' HIV Care Ryan White Part B Program and the Tuberculosis Prevention and Control Program.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), a SAMHSA funded grant, continues efforts to increase access to screening, assessment, and referral for appropriate services for children ages 0-8 in Muscogee County. DBHDD is partnering with the Department of Public Health (DPH) to implement the strategic plan. The project is in year 5 of 5 years, and is currently focused on increasing mental health screening of young children in the school and early education settings using the ASQ and ASQ – SE (Ages and Stages Questionnaire – Social Emotional Assessment), increasing outreach to pediatricians to include mental health screening in their processes, and training the young child workforce on the social emotional development of young children. These goals are being accomplished through many local partnerships and the project has been able to establish many family, physician and community service champions.

Project LAUNCH Georgia addresses three main **goals**: (1) expand early identification and linkage of children at-risk for social-emotional and behavioral delays to provide timely support for children and parents, (2) increase the capacity of providers of Muscogee County who serve young children and to provide integrated comprehensive behavioral health services and (3) build common infrastructure between child serving agencies at the state and local levels.

Sustainability plans are being finalized for Project LAUNCH through several partnerships and new funding streams. Some examples include, the new program LENA Start, a program for parents to increase language nutrition for their young children through training and a vest that the child wears to count the words he/she is learning throughout the day. This program has been embraced by the Muscogee County community with parents already enrolled and participating in the program reporting positive results. Another funding stream identified is a grant that the Department of Public Health applied for, Healthy Start. This grant will allow home visiting to expand in Muscogee County and also supports a fatherhood initiative and healthy mother/baby programs. Reach out and Read is also expanding in the Muscogee County area, through the support of new partnerships formed through Project LAUNCH, which will continue to provide literacy tools for physician offices. Help me Grow is a Department of Public Health initiative to better connect families with services across Georgia that has also been supported by Project LAUNCH efforts.

State Efforts to Develop Systems of Care

DBHDD has been leading this system of care development for over 30 years. The initial efforts began with a federal grant, the **Child and Adolescent Service System Program**. Out of this effort was the establishment of local interagency (MATCH) committees; development of a

statewide family organization, the Georgia Parent Support Network (GPSN) which is Georgia's Federation of Families for Children's Mental Health chapter; and development of a State Strategic Services Capacity Building Plan that was used as the foundation for the first separate Children's Plan for the MHBG.

Even with service development and expansions as a result of the planning effort, DBHDD continued to hear from agency partners that child and adolescent mental health services were not available or adequate to meet the needs of youth and families. In response to specific concerns regarding access to mental health services DBHDD launched a **Quality Improvement Initiative** and contracted with Sheila Pires of the Human Services Collaborative in Washington, D.C. a well-known expert on Building Systems of Care to lead this initiative. The SOC QI Initiative provided the impetus and foundation for identifying needed service and system improvements and for initiating strategic planning to strengthen the infrastructure throughout the state.

In October 2004, Georgia was awarded a **Child and Adolescent State Infrastructure Grant** (CASIG) from SAMHSA to help expand the state's infrastructure for developing comprehensive systems of care to meet the needs of youth with SED, substance abuse, and co-occurring disorders and their families. This grant focused on building systems of care through workforce development; expansion of the youth and family voice in service design and delivery; development of financing strategies; and development of interagency mechanisms. DBHDD was also awarded a Substance Abuse Coordination grant from the Center for Substance Abuse Services in October 2005 and these efforts were integrated with the CASIG project.

In December 2006, Georgia received the **Alternatives to PRTF Demonstration Grant** from CMS as previously mentioned and described. This provided the opportunity to develop a best practice system of care approach to service delivery, High Fidelity Wraparound and establish Care Management Entities. In 2009, as aforementioned, Georgia received the **CHIPRA Quality Demonstration Grant** enabling DBHDD to evaluate and refine the CME model as well as develop the CPS-P and CPS-Y training and certification program further solidifying system of care approaches to service delivery.

In 2009, Georgia was one of seven states selected as a **SAMHSA Healthy Transitions Initiative (HTI)** grantee. The HTI grant was aimed at addressing the needs of transition age young people with mental health needs focusing on service, policy and infrastructure components. The goal was to improve outcomes for youth and young adults ages 16 through 24 with serious mental health challenges and to transition them to adulthood in areas such as education, employment, housing, and accessing mental health services. Two demonstration sites implemented the Transition to Independence Process (TIP) Model developed by Dr. Rusty Clark. This person- centered model uses transition facilitation coaches to assist young people in meeting their individualized transition plans.

A key component to successful transitions includes young adults accessing and consistently utilizing adult mental health services when needed. To assist in the transition from the child and adolescent system to the adult mental health system, the HTI grant brought these two systems together. DBHDD held internal meetings where policy leadership from both systems reviewed the current DBHDD Provider Manual and examined areas where transition language, planning and services could be added to the current spectrum of services and supports. To this end, DBHDD developed a policy, 'Best Practices for Serving "Emerging Adults" - Transitioning from Late Adolescence to Young Adulthood' and a toolkit for providers. In addition, DBHDD and the Georgia Vocational Rehabilitation Agency developed a MOU to support enrollment of young adults in IPS Supported Employment. The agreement provides funding and dedicated mental health VR counselors to serve adults and transition age youth and young adults (16-21) with mental health conditions.

In July 2013, DBHDD was awarded a five-year **System of Care Expansion Implementation Grant**. This grant, **Georgia Tapestry**, provides DBHDD, in partnership with other child-serving agencies, the opportunity to further implement infrastructure and services which support development of a more effective service delivery system. The project goals and objectives were derived from the initial IDT plan. The goals are to: Implement policy, administrative and regulatory changes; Develop or expand services and supports based on the SOC philosophy and approach; create and improve financing strategies; provide training, technical assistance and workforce development; and, generate support and advocacy.

Georgia Tapestry developed and funds two co-occurring clubhouses. The pilot project vision is to improve outcomes for youth and young adults ages 15 through 21 with serious mental health challenges and substance use issues by supporting areas such as education, employment, social skills and accessing mental health services through a co-occurring clubhouse model.

DBHDD remains committed to family and youth inclusion across all levels of service delivery and supports the workforce development of certified peer specialists (CPS). Recovery oriented SOC supports training for parents with lived experience as parents of youth with serious emotional disturbances (CPS-P). A separate curriculum was also developed for youth and young adults with lived experience navigating the behavioral health service delivery system (CPS-Y). Additionally, to support youth/young adult leaders with lived experience to grow into advocates, advisory partners and CPS, a Youth Leadership Academy has been developed and implemented. The Academy aims to promote the development of youth and young adult leaders through creating a learning environment designed to cultivate youth voice. It provides robust training, tools and activities to increase inclusion of youth in policy, governance and service delivery. It was designed to build capacity for potential youth candidates to become employed CPS and/or Youth MOVE leadership. In addition to family and youth support and advocacy development,

the grant initiative supplemented the expansion of family and youth service organizations, including local Federation of Families for Children's Mental Health chapters as well as Youth M.O.V.E. chapters state-wide.

Training and technical assistance is another area of concentration. Grant funding supported multiple training initiatives on relevant topics to support system of care efforts statewide. The Interagency Directors Team (IDT) and Local Interagency Planning Team (LIPT) chairs were trained by Dr. Vivian Jackson on *Cultural and Linguistic Competence at the Organizational and Systemic Levels* and Ellen Kagen from Georgetown University on Effective Leadership for Systems Change/System of Care Leadership. A two-day Trauma Informed Systems training, originally developed by the National Child Traumatic Stress Network, takes a strength-based approach to providing an understanding of how to recognize, approach and respond to children and families impacted by acute and complex forms of trauma. The curriculum is designed to teach basic knowledge, skills, and values about working with children who have experienced trauma and have been involved with any child serving system such as child welfare, education, or juvenile justice. Types of providers trained across all six DBHDD regions included clinical directors, juvenile probation or parole, clinicians, licensed professionals, and wraparound supervisors. The annual System of Care Academy was held this summer, *Celebrating Our Progress: Vision to Reality* was selected as this year's theme. The SOC Academy was hosted by DBHDD and the IDT and had over 500 attendees including community providers, child serving agencies, stakeholders, families and youth.

Local Efforts to Develop Systems of Care

The Peachstate Wraparound Initiative (aka, KidsNet Rockdale) was a Center for Mental Health Services grantee for the Child Mental Health Initiative. With federal support, this program demonstrated use of a system of care model in a suburban area of the state. KidsNet Rockdale expanded in their service area and to other sites in the state and supported development of systems of care in these areas. Technical assistance was provided to a wide variety of partners, including local juvenile courts in several counties; the Governor's Office for Children and Families; DJJ; other local areas interested in system of care development; and local universities. With the support of the Governor's Office of Planning and Budget, the DBHDD and DJJ, these sites were sustained beyond federal funding and became part of the broader Georgia System of Care development.

In October 2005, the former DHR launched a pilot to model system of care development in Savannah, Georgia. KidsNet Savannah developed coordinated service delivery approaches for youth with SED and their families and developed a System of Care Policy Council to oversee system of care development. DBHDD staff provided support in order to ensure integration with statewide development. The development of KidsNet Savannah also became the foundation for

the implementation for the roll-out of the PRTF Waiver Service Demonstration as well as the EAI Grant that was awarded to DBHDD.

KidsNet Northwest began their work with an interagency case management project focused on youth involved with juvenile justice with participation from public health, juvenile justice, and mental health and subsequently expanded services to youth and their families building on the model of KidsNet Rockdale. DBHDD provided support to attend national system of care training events for technical assistance and consultation as needed for development activities. KidsNet Northwest received a SAMHSA CMHS Child Mental Health Initiative grant in October 2008.

In FY10, KidsNet Rockdale and KidsNet Northwest re-tooled and re-branded their initiatives. They maintained system of care approaches to service delivery and also enhanced their SOC by receiving training to become Care Management Entities (CMEs) under CBAY.

State Efforts to Develop Interagency Structures to Support SOC Development
In the absence of a Children's Department, there are state, regional and local collaboratives in place to support system of care development.

A State Level Children's Behavioral Health Service Collaborative was initially formed to oversee the implementation of the goals and objectives of the CASIG. The Collaborative received training on development of systems of care for youth that included information on lessons learned from federally funded local systems of care as well as information from developing local systems of care in Georgia. The State Collaborative known as KidsNet Georgia, developed consensus for and began steps toward meeting a strategic plan to build the system of care infrastructure needed for behavioral health service delivery to youth and their families. The Collaborative focused on four areas: Family and Youth Involvement, Financing, Interagency Collaboration and Workforce Development.

With the end of the CASIG grant, the functions of this group were sustained through the formation of the Interagency Directors Team (IDT) created by DBHDD in May 2011. The IDT is the state's multi-agency SOC leadership collaborative, whose mission it is to manage, design, facilitate and implement the SOC in Georgia. The IDT is a sub-committee of the Behavioral Health Coordinating Council (DBHDD) (OCGA 37-2-4). The membership consists of state agency representatives as well as partner organizations. The state agency partners include the Georgia Departments of Behavioral Health and Developmental Disabilities, Community Health (State Medicaid Authority), Early Care and Learning, Education, Human Services (Child Welfare), Juvenile Justice, Public Health, and Vocational Rehabilitation. The partner organizations include the four Care Management Organizations under contract with DCH; Amerigroup Community Care, CareSource, Peach State, and WellCare. In addition, three

provider associations; Georgia Association of Community Service Boards, Georgia Alliance of Therapeutic Services for Children and Families, and Together Georgia. Also, three family/children's advocacy/support organizations: Georgia Parent Support Network (the State Federation of Families for Children's Mental Health Chapter), Voices for Georgia's Children and Mental Health America of Georgia. There are two Georgia State University partners: Center of Excellence for Children's Behavioral Health (COE) and Center for Leadership in Disability. The remaining partners include the Get Georgia Reading Campaign for Grade Level Reading and The Carter Center. Lastly, the Centers for Disease Control and Prevention (CDC) serves as a consulting member.

The IDT initially adopted the following strategies to guide its work:

- Develop and expand services and supports, while focusing on individualized approaches to care management
- Create and improve financing strategies
- Provide training, technical assistance, and workforce development
- Generate support and advocacy
- Implement policy, administrative, and regulatory changes
- Use evaluation to continuously improve the system

These strategies were based on nationally recognized system of care development strategies.

The IDT more recently has sharpened its focus and has worked on development of a state System of Care Plan. Over 15 months (March 2016– May 2017), under direction of the Behavioral Health Coordinating Council (BHCC), and with the support of the Center of Excellence for Children's Behavioral Health and the National Training and Technical Assistance Center for Children's Behavioral Health, the IDT developed the 2017 Georgia SOC State Plan. Children, adolescents, and emerging adults with SED are the focus of the plan. The IDT identified the five focus areas of this plan: **Access**, **Coordination**, **Workforce Development**, **Funding and Financing**, and **Evaluation**. **Access** and **Coordination** were deemed the most critical areas of focus. **Workforce Development** and **Funding and Financing** strategies can be conceptualized as methods through which to increase **Coordination** and **Access**. **Evaluation** wraps around the entire plan, and feeds back into future planning efforts. Each focus area is aligned to a goal as well as short- and long-term strategies for achieving these goals. Below is excerpt from the Georgia System of Care State Plan 2017 which describes the focus of each area of these areas.

Access to an array of community-based services and supports is a core component of any functional behavioral health care system. For children and emerging adults, access to mental health services is critically important for early identification of mental health concerns and linkage to appropriate services. A focus on access was chosen to support children and families in their access to and navigation of mental health care services in Georgia. Short-term strategies to increase access to care include service mapping for behavioral health service utilization,

increasing behavioral health services in schools, and improving families' abilities to navigate the current system. Long-term strategies include recruiting practitioners in shortage areas, strategically increasing the use of telemedicine and telehealth services, and increasing continuity of care.

At the heart of the SOC approach are **coordination** and collaboration between child-serving agencies and organizations, and between the child, family and the larger system. Coordinated communication systems between local, county, regional, and state bodies are a vital feedback loop to ensure that local and regional needs and resources are understood, and state and county-level policy objectives are being achieved. This area of focus was chosen as an integral part of a coordinated network that serves children and families. Short-term strategies to increase coordination include increasing training on SOCs for stakeholders and building and maintaining feedback loops between local, regional, and state agencies and systems. Long-term strategies include creating and utilizing a common language as it relates to discussing SOC principles, and addressing gaps in the crisis continuum by adding additional levels of care that will address capacity and acuity concerns: Crisis Respite; Intensive Care Coordination (IC3), and therapeutic foster homes.

The behavioral health **workforce** in the United States is inadequate to meet current and growing service demands and behavioral health needs. Workforce issues can be compounded by geographic regions and characteristics, with rural areas at even more risk of experiencing workforce shortages. As over half of Georgia counties are designated as rural, the IDT has identified workforce a major barrier to access to care for children and families. To develop, maintain, and support a culturally competent, trauma-informed workforce to meet the needs of children and youth, short-term strategies including targeted expansion of educational and financial incentives to address behavioral health workforce shortages and developing a clearinghouse of evidence-based educational materials that will be employed along with the long-term strategy of developing a state mental health workforce plan across agencies.

Cross-agency commitment to effective and efficient spending is necessary for a comprehensive, community-based, family-driven, youth-guided, culturally competent and trauma-informed SOC framework to operate in Georgia. The braiding and blending of interagency funds is a key way for multiple agencies to achieve more effective and efficient spending. In the short term, strategies to solidify interagency funding of the IDT as the oversight body for the SOC in Georgia and create and utilize SOC guiding principles for contract development will help to address this focus area. The long-term strategies to establish funding and **financing** for the SOC consist of reviewing financial mapping reports to find opportunities to braid or blend funding and the collaboration of IDT agencies in applying for and releasing funding opportunities and procurements when behavioral health is a key component.

Ongoing **evaluation** of Georgia's child-serving systems is critical to sustainability and success. To ensure that the proposed SOC is achieving its desired goals, the IDT will review evaluation tools to identify key metrics applicable to Georgia and provide these tools to the state, local, and regional teams as well as other child-serving systems to self-evaluate their SOC work. The long-term strategy for evaluation is for the IDT to institute and maintain a continuous quality-improvement process utilizing identified metrics that will be reviewed annually and regularly reported to the BHCC.

In addition to work which is the focus of the IDT, the IDT membership follows and participates in legislative efforts focused on improving the system of care for youth with SED. IDT members or the agencies they represent are often asked to provide information to various study committees. In the past couple of years there have been four committees that had an interest in the target populations of the IDT:

- Children's Mental Health (House)
  Examined early intervention and prevention services; identifying available resources for children with mental health issues; and evaluating possible improvements in delivery of services.

- Health, Education & School Based Health Centers (House)
  http://www.house.ga.gov/Committees/en-US/School_Based_Health_Centers.aspx

- Preventing Youth Substance Use Disorders (Senate)
  http://www.legis.ga.gov/legislation/en-US/Display/20152016/SR/487

- Rate of Diagnosis for Children with Attention Deficit Hyperactivity Disorder (Senate)
  http://www.legis.ga.gov/legislation/en-US/Display/20152016/SR/594

During the Summer of 2017, the Governor appointed a new commission to focus on children and families, the Commission on Children's Mental Health. The Commission was charged with providing recommendations on improving state mental health services for children. The commission included health care experts, state leaders and children's advocates. The commission reviewed programs and areas identified, as well as the funding necessary to make improvements, and returned eight recommendations to the Governors. Seven of the eight received funding.

Local Interagency Planning Teams (LIPTS)

Local Interagency Planning Teams (LIPTS) have evolved through several years even since they were mandated into law. They are seen as existing collaborative bodies that have value as community stakeholders interested in youth with SED and their families. LIPTs are established at the county or multi-county level, depending on the size of the community, the number of children at risk, and the geographic availability of resources. The purpose is to improve and

facilitate the coordination of services for children with severe emotional disorders (SED) and/or addictive disease (AD). Goals are:

- To assure that children with SED and/or AD and their families have access to a system of care in their geographic area;
- To assure the provision of an array of community therapeutic and placement services;
- To decrease fragmentation and duplication of services and maximize the utilization of all available resources in providing needed services
- To facilitate effective referral and screening systems that will assure children have access to the services they need to lead productive lives
- Membership of the Local Interagency Planning Team (LIPT) includes representatives from each of the following: Division of Family and Children Services, Department of Juvenile Justice, mental health service providers, Rehabilitation Services, Education, Public Health, Family Connection Partnership, and Parents or parent advocates.

The LIPT network has remained strong and they are monitored by the DBHDD Regional Child and Adolescent (C&A) Specialists who attend meetings and serve as the agency's voice and anchor in the approximately 119 LIPTs throughout the state. Many of the LIPTs from the smaller districts have collaborated and meet jointly.

Regional Interagency Action Teams (RIATS)

Regional Interagency Action Teams (RIAT) created after the LIPTs were not required by law, and were intended to provide a feedback loop for collaborative learning regarding the operation of the LIPTs. Regional Teams were initially established in all 6 DBHDD regions. These teams met to identify shared and cross-cutting issues related to children's behavioral health as identified in the LIPT processes. Goals were:

- To assure that gaps in services are identified
- To assure that barriers at the local level are identified and addressed
- To assure a common vision at the regional level
- To decrease fragmentation and duplication across partners
- To identify strengths in processes

Membership of the RIAT included the chairpersons of the LIPTs located within the region, regional representation by mandated agencies, LIPT trainers, and family representatives. The teams were facilitated by the DBHDD Regional C&A Specialists. Information from these meetings was to be provided to the DBHDD Regional Services Administrator, the DBHDD Directors of Child and Adolescent Mental Health Services and Addictive Disease Services, and the IDT. The findings were to be used to improve processes and help inform the development of the State Plan for the Coordinated System of Care. Unfortunately, there was variability in the work of the RIATs and many of them did not functioned as intended. Most RIATs discontinued meeting. The purpose and vision for these teams is being revisited and reconsidered.

Recommendations have been made to the Interagency Directors Team regarding their recreation and sustainability.

The DBHDD Regional C&A Program Specialist positions were established to ensure that children receive appropriate mental health and substance abuse services. They serve as a consultant and resource in the regions across child serving agencies. These staff members are involved in various activities which support a system of integrated services. As related to LIPT and RIAT involvement the Program Specialists: facilitate and coordinate RIAT meetings where RIATs exist; coordinate multi-agency planning efforts with LIPTs; attend LIPT meetings and present cases as needed; conduct training and provide technical assistance; assist in the development of local interagency agreements; act as a liaison between LIPTs and DBHDD. The Program Specialists also work to ensure continuity of care across services and child-serving systems. They educate other child serving agencies and stakeholders on DBHDD policies, procedures, and practices; provide technical assistance to DFCS and DJJ to ensure a MH connection in the community; serve as bridge to connection to other services such as AD and DD; and identify growing regional trends related to continuity of care in inter- and intra- related service delivery systems.

Criterion IV: Targeted Services to Homeless and Rural Populations

Homeless

The Georgia Alliance to End Homelessness (GAEH) developed the Georgia Campaign to End Child Homelessness. According to a plan developed out of this effort, there are over 45,000 children who experience homelessness in Georgia each year. In addition, according to the Georgia Department of Community Affairs 2015 Report on Homelessness, during the Point in Time Count in January 2015, at least 13,790 people were literally homeless in Georgia which is a 19% decrease from 2013. Children under the age of 18 comprise 18% of the homeless population and 13% of the homeless population are youth between the ages of 18 and 24. As relates to family composition, 30% of the total homeless population are in families with children.

The 2014 America's Youngest Outcasts: A Report Card on Child Homelessness published by the National Center on Family Homelessness at American Institutes for Research provides state rankings based on four domains: extent of child homelessness (adjusted for state population); child well-being; risk for child homelessness; and, state policy and planning efforts. Georgia ranks 40th out of 50 on the composite score. For each domain, the ranking was as follows: 28th for extent of child homelessness; 43rd for child-well-being; 49th for risk for child homelessness; and, 24th in state policy and planning. As relates to extent of child homelessness, in 2010-2011 there were 63,818 homeless youth and in 2012-2013 it had increased to 73,953 youth. Georgia continues to struggle with child poverty and continues to lag in economic well-being. These factors have a tremendous impact on child homelessness in this state.

DBHDD collects data on living status of youth with SED enrolled in services. Providers are required to gather information on living situation upon enrollment in services. Providers under contract or agreement with DBHDD provide early intervention and mental health treatment services to identified youth with SED and their families who are at risk for homelessness or homeless and ensure that appropriate interventions are provided to meet the needs of this high-risk target population in Georgia. The Core Customer definition for eligibility for services identifies priority groups for state funded services. Youth who are homeless and who are at risk of homelessness are included in the priority group targeted for state funded services. Comprehensive mental health services are available in all regions for children and adolescents with SED who are homeless. The total unduplicated Child and Adolescent DBHDD MH consumers authorized services during FY16 where their living situation was identified as either "Homeless - Shelter" was 97.

Youth with SED may have runaway behaviors, families with economic pressures and poverty, poor familial relationships, substance abuse and/or family substance abuse, violence, physical, sexual and emotional abuse and neglect within the family. Some youth with SED also have the "throw away" experience in which parents or caretakers tell them to leave the home or do not receive support when the youth are placed outside the home and parents are reluctant to have them return to their homes. These risk factors can increase the chances for homelessness for the family and/or the youth with SED. Youth who are in state custody through the child welfare system often do not have safe family members who are involved with them and they oftentimes end up in emergency shelters, child protective custody or foster care. Many of these youth grow up in the child welfare system and age out at the age of eighteen only to sign themselves back into care for access to Independent Living Programs, funded through DFCS.

Youth who are aging out of residential services or PRTFs are often the more complex youth to plan for services and supports appropriate to meet their needs. This group of youth with SED often drops out of services, become homeless and/or become involved with the criminal justice system. With the High-Fidelity Wraparound Program, youth served in or at risk of PRTFs up to age 21 can be offered the option of home and community-based services. Youth who are homeless or at risk of homelessness are a priority population to be served by DBHDD providers.

DBHDD has participated in collaboratives focused on homelessness. Since FY19 the Supported Housing Unit Director has been DBHDD's primary contact. In addition to past involvement with coalitions in Georgia to address homelessness, she is a current member of the NASMHPD Housing Task Force. In the past the Assistant Director of Adult Mental Health participated in the United States Interagency Council on Homelessness (USICH) Criteria and Benchmarks for Ending Family Homelessness: Stakeholder Input Session #3 (June 8, 2017). This session was designed to allow stakeholders to provide input on the proposed benchmarks and the questions to

assess a community's progress in achieving the goal of ending family homelessness. This input will be used to help identify where further refinements are needed. The Supported Housing Unit Director is also responsible for implementation of the Projects for Assistance in Transition from Homelessness (PATH) Program. One of the state's ten PATH Teams, the Community Advanced Practice Nurses (CAPN), provides outreach and adult mental health assessment services at two women & children's shelters: Atlanta Day Shelter for Women & Children and Atlanta Children's Shelter.

In FY19 the OCYF contracted with the Georgia Parent Support Network to begin outreach services for homeless youth.

The DBHDD Regional Field Offices and their providers also participate in and support local efforts related to improving service delivery to homeless women and children. The Region 2 Field Office staff coordinate with child welfare regarding homeless children and assist in identifying resources for their parents. APEX, DBHDD's school-based mental health program also provides counselors who can link families to housing resources as needed. In Macon, Georgia, Apex is co-located with First Choice Primary Care (FQHC) in an elementary school. In Athens, Georgia, Advantage Behavioral Health Services has led the development of the Athens Resource Center for Hope which includes formal partnerships among Advantage Behavioral Health Systems, Athens Nurses Clinic, Live Forward (Formerly AIDS Athens), Athens Area Homeless Shelter, and Little Angels Daycare. Specifically, Advantage provides outreach and support services within a co-located facility that also houses the Athens Nurses Clinic and Live Forward. Through this partnership they are able to provide collaborative case management and support services that meet the health, financial, and overall stability needs of local homeless individuals and families. In Region 3, the Field Office provides assistance to women's shelters and domestic violence shelters who are needing help with locating housing and behavioral health providers. If the person referred meets criteria, they are linked with one of the state funded providers to complete the GHVP. The PATH teams have also placed women with children into the GHVP. In Region 5, Gateway CSB works with the local Homeless Coalitions in their service area. One of the Homeless Coalitions is chaired by the director of a children's shelter. This coalition has a particular interest in the needs of children with SED who are homeless. In another service area of the region, the provider, Pineland CSB, uses its Shelter Plus Care program to support the needs of women and children. Currently they have 3 households with women and their children in their Shelter Plus Care Services.

Rural Services

Rural is defined as those counties not included in Metropolitan Statistical Areas (MSA). Five of the six DBHDD regions have rural areas. As such, service to persons living in rural localities is of primary concern. Mental health service planning for rural areas occurs at a local level through the six DBHDD Field Offices. Field Offices, through input from their Regional Advisory

Councils, public forums, public surveys, focus groups, and youth and family satisfaction surveys gather information to better plan for services in all areas of the state, particularly rural areas.

DBHDD contracts with providers to cover all areas of the state. There are twenty-four CSBs, as well as additional comprehensive service providers, and specialty providers. GCAL provides people seeking behavioral health services with information and access to comprehensive outpatient and crisis services throughout the state.

There is a significant behavioral health professional workforce shortage in Georgia, creating challenges to provide all services in all areas. In many counties, there are few to no licensed behavioral health practitioners, and DBHDD is often in competition with the educational, juvenile justice, and child welfare organizations for these critical staff. In addition, transportation is a problem for consumers in some areas. Medicaid consumers utilize Medicaid transportation systems to get to services; however, transportation services have not been readily available to all persons.

Increasing access to services has been a major thrust of the DBHDD and its Regional Offices. Providers are required to deliver services out of the clinic setting. Although services for children and adolescents have been able to be delivered outside of the clinic since the early nineties, implementation of the Medicaid Rehabilitation Option has allowed for a broader array of service options to be delivered in homes and other locations. Providers are required to have extended service hours on weekdays and weekends as well. Some providers also send staff to juvenile courts, child welfare offices and schools to make services more accessible to youth and their families. In addition, there is a higher level of reimbursement for providers delivering services outside of a clinic site, where the person lives or goes to school.

Two of the services implemented in the Rehabilitation Option are Intensive Family Intervention (IFI), and Community Support (CS). These services can be delivered in any setting and as a result are delivered in closer proximity to the youth and based on the individual needs of the youth and their families. The traditional model of (IFI), with a strong team identity for services, is tested heavily in rural areas in which staff travel long distances to see consumers. A healthcare professional shortage in rural areas of the state also affects the ability to develop service capacity for IFI due to the need for a higher level of professional and credentialed staff. Less intensive levels of mobile service like CS have proven to be easier to implement in rural settings. The challenge is to implement these model approaches to service in cost efficient ways and promote access to services for all consumers in need. Mobile crisis is also available statewide.

One of the initiatives put forward by DBHDD to expand services throughout the state, including rural areas, is a school-based mental health project. This effort mentioned previously is referred to as Georgia Apex. DBHDD provides grant funding to 24 Community Service Boards and three

additional providers to support the integration of community mental health professionals in the learning environment of targeted schools. Focusing on disparate populations, as well as local schools with identified need around school climate, the overarching goal is to increase access to mental health services and to ensure increased and sustained coordination between community mental health providers and local education agencies.

DBHDD has been working with the state's Department of Community Health to promote the use of telemedicine as an access tool for rural areas. Telemedicine continues to be an emerging avenue for dealing with the shortage of physicians and other practitioners in rural areas and Georgia is exploring additional ways to promote the effective use of telemedicine into the system of care.

Georgia maintains and is growing the following approaches to telemedicine:

- The state continues to use teleconferencing for clinical supervision and discharge planning purposes in its state facilities;
- Teleconferencing can be utilized for the provision of Community Transition Planning, a transition support services which provides support services to individuals in the last few days of a facility admission, promoting post-inpatient community engagement;
- Georgia's Medicaid State Plan continues multiple service definitions which allow telemedicine (traditional services such as Physician Assessment, Diagnostic Assessment). In 2017, telemedicine capacity was expanded to allow non-English speaking individuals to access a same-language speaking practitioner via telemedicine for any Core and most Specialty services.
- There are over 60 DBHDD provider sites that are participating in the Global Partnership for TeleHealth [http://www.gatelehealth.org/about/partnerslocations/]. All state hospitals are telemedicine enabled.
- Both of the DBHDD's Mobile Crisis vendors has telemedicine capacity.
- Approximately a dozen more private and non-profit affiliated vendors are telemedicine enabled

  DBHDD provided telemedicine capacity grants to XX # of youth mental health providers for youth behavioral health services and 12 Community Service Boards specific to ASD services expansion.

DBHDD continues its telemedicine interactions to promote quality stabilization, treatment, and transition. The DBHDD policy focuses on three key interaction areas:

- Telemedicine between DBHDD facilities and/or offices
- Telemedicine between DBHDD facilities and other medical facilities, for example:
  - ✓ Consultation with Emergency Departments or Crisis Stabilization Programs regarding referral for admission
  - ✓ Medical care consultation from specialists
- Telemedicine between DBHDD facilities and community entities, for example:

- ✓ Discharge planning with Community Providers of behavioral health or developmental disabilities services
- ✓ Sheriff Departments
- ✓ Civil commitment hearings

Lastly, LIPTs, our local system of care infrastructure covers all 159 counties. They have had a major impact on interagency collaboration and resource development for youth in rural communities. The natural supports as well as more formal systems have a forum for working together to develop specific community plans for youth with SED who might otherwise need to leave their communities for adequate services.

Criterion V: Management of Human and Fiscal Resources

Financial Resources

Since the late eighties, the funding level for community-based child and adolescent mental health services has increased. This increase has come because of new state appropriations, redirection of existing funding from closure of hospital beds, and federal funds. Over $60 million dollars is available to fund child and adolescent mental health services. Funding has supported an expansion of services including traditional outpatient services, community support, school-based mental health services, intensive family intervention services, mental health clubhouses, mobile crisis and crisis stabilization units. Historically, the majority of state and federal mental health block grant funds were allocated via contracts primarily to public providers of mental health services for the range of community-based mental health services. With the change to an FFS model for children and adolescents, DBHDD primarily has provider agreements for services and fewer contracts with grant in aid allocations.

For SFY20, there is $6,683,546 of MHBG funds available to support child and adolescent mental health services and administration. The majority of funding, $6,232,985 provided for child and adolescent services is contracted and supports the delivery of Care Management Entity Services (CME), Mental Health Clubhouses, a transitional age youth and young adult peer center, and first episode psychosis programs. The remaining amount of $450,561 is used to support training of providers and to support further development of family support/network organizations.

The Medicaid Rehabilitation Option, implemented in FY2002, enabled the state to offer an expanded array of services in settings other than mental health centers, greatly enhancing the scope and focus of the service system. With this shift, the DBHDD also received the Medicaid "State Match" dollars in its budget, and became "at-risk" for managing the utilization of Medicaid mental health services. With the initial change to Medicaid managed care, over $20 million dollars was removed from the DBHDD budget to provide for state match for the Care Management Organizations (CMOs). With the additional change to a foster care CMO, DBHDD

transferred $24 million of the state child and adolescent mental health budget to DCH to fund the services to foster care and juvenile justice youth. As previously mentioned, DBHDD does not have responsibility for provision of mental health services to foster children. All physical and mental health services are the responsibility of DCH and the foster care/juvenile justice CMO. The state funds remaining support services to youth who are uninsured, disabled and receiving adoption assistance.

Human Resources

DBHDD recognizes the critical importance of staff development and training in supporting the delivery of quality services. DBHDD developed a Standard Training Requirement that was submitted to and approved by the Department of Community Health (DCH), the state's Medicaid agency, as part of the revision of Georgia's state plan for Medicaid Rehabilitation Option services. DBHDD utilizes a training curriculum, Relias Learning (online learning), as a training tool for preparing paraprofessionals to work in the field of mental health; all paraprofessionals are required to complete a list of required courses shortly after hire. Demonstrated mastery of each topic area within the Standard Training Requirement is necessary in order for paraprofessionals to provide either state-funded or Medicaid-reimbursable services in Georgia. This training curriculum includes courses such as Coordinating Primary Care for Needs of Clients; Mental Health Issues in Older Adult Populations; Cultural Issues in Mental Health Treatment for Paraprofessionals; Bipolar Disorder in Children and Adolescents, Overview of Family Psycho Education – Evidence based Practices, Alcohol and the Family for Paraprofessionals, Co-Occurring Disorders; and an Overview for Paraprofessionals, Suicide Prevention, and Suicide the Forever Decision.

In addition, key trainings on basic topics such as documentation and incident investigation are routinely offered for DBHDD providers. The **Office of Human Resources/Learning** has created DBHDD University and has implemented a Learning Management System (LMS) that provide online educational opportunities for both DBHDD staff and community providers. The LMS provides for course registration, record of course completions, assessment grades, transcripts, and printable course certificates.

The **Office of Human Resources/Learning** facilitates many other training and development activities that are offered through DBHDD. Providers and system of care partners have received training in Trauma Informed Care, Transitions to Independence Process, Dialectical Behavior Therapy, Trauma-focused CBT, Crisis Planning and Safety Planning, Adolescent Co-Occurring Mental Health and Substance Use Disorders, Suicide Prevention of at-risk populations, Mental Health Training for Spoken Language Interpreters and Training for Mental Health Clinicians in Use of Spoken Language Interpreter Services, Cultural Competence and System of Care Leadership and Approaches.

DBHDD funds and sponsors an Annual Georgia System of Care Academy with the most recent one, the 12th System of Care Academy, held in June 2019. The Annual System of Care Academy provides a shared value, principles, and practice focused conference. It is held each summer and key staff from DBHDD, Community Mental Health, Addictive Diseases, DFCS, GA DOE, DJJ, GVRA, DPH, DECAL, DCH programs, other professionals, families and youth from across the state are invited.

In addition, there was a separate youth track where youth were provided sessions on leadership, career development, building advocacy skills, esteem building, suicide prevention education, and domestic violence education, and others. There were over 400 attendees with over 100 families and youth.

Community Mental Health Services Provider symposiums are held to present shared values, philosophies, expectations, and training related to the service system guidelines and policies. These symposiums, known as provider technical assistance and training days are held once a year. All providers are required to attend. In October 2017, DBHDD will host the Community Mental Health Training and Technical Assistance Symposium. The Symposium is organized according to a clinical track and a leadership track. There will be sessions related to all providers, both adult and child and adolescent such as Accountable Care Service Delivery System Solutions, Recovery, Beyond Trauma, Treating Co-Occurring Disorders, Suicide Prevention, Treatment for Young People with 1st Episode Psychosis, Motivational Interviewing, and Crisis Management Strategies. There will be specific sessions held of interest to child and adolescent providers: Transition Age Youth Services and Support, Child and Adolescent Medications, LBGTQ, and Military Culture and Families.

In addition to a focus on clinical training, Office of Children, Family, and Young Adults implemented an *Occupational Stress Management* module for Crisis Stabilization Unit (CSU) providers and Psychiatric Residential Treatment Faculties (PRTF). This training module focuses on the occupational wellness of our residential and high-level treatment workforce. This module was piloted beginning in mid-2016 with training of Secondary Traumatic Stress (STS) training using both Train-the-Trainer and onsite training modalities to train all direct care staff in CSUs and PRTF. During the first year (2017), PRTF and CSU executive leadership and training personnel receive quarterly resources and job aids from DBHDD surrounding STS, self-care, and wellness to distribute to their direct care staff.

DBHDD partnered with the University of Georgia School of Social Work (SSW) to assess the professional development needs of the workforce. The assessment was divided into two phases utilizing a mixed methods approach (both quantitative and qualitative methodologies). One phase consisted of an online survey administered to direct care staff and supervisors at DBHDD facilities and agencies (n= 596 respondents). A second phase consisted of focus groups with

representatives of supervisors and direct care staff from the various treatment facilities and agencies under the auspices of DBHDD (40 participants). The objective of the assessment was to gain a comprehensive assessment of the behavioral health workforce specifically the Office of Children, Young Adults, and Families to guide the development of a data driven workforce development plan and initiatives.

The findings are currently being used to drive our workforce development initiatives and opportunities. These initiatives will include utilizing more technology such as asynchronous learning platforms to increase access to training and development especially for our hospital and residential facility workforce. Also, significant findings will be used to drive training and development content for our Annual Georgia System of Care Academy and Community Mental Health Training and Technical Assistance Symposium as well as other training and development events.

In addition, utilizing the availability of grant funds, DBHDD has been able to support providers, families and youth to attend national system of care conferences such as the National Federation of Families for Children's Mental Health Conference, the University of South Florida Research and Training Conference, the Alternatives 2017 conference, a SAMHSA small group meeting on Wraparound Innovations and a SAMHSA small group meeting on Medicaid Managed Care.

With funding from a CHIPRA grant Georgia developed a training and certification process for parents of youth with behavioral health conditions. Individuals who complete this course and certification work as Certified Peer Specialists for Parents (CPS-P) in Georgia's continuum of care for children, youth and families. A curriculum has also been developed to certify peer specialists to work with youth (CPS-Y). The Family Liaison in the Office of Recovery Transformation has led the development of the Certified Peer Specialist –Parent curriculum as well the Certified Peer Specialist-Youth curriculum. To assist with the latter, a young adult was hired to work on curriculum with other youth leaders to ensure and facilitate youth voice in the design of the curriculum. Over 100 parents and 30 youth have been trained and certified.

Emergency Service Provider Training

All services in the Georgia DBHDD system are provided under contract or agreement with private or public providers of behavioral health services. Local providers work with emergency personnel such as Sheriff's Departments, Hospital Emergency Rooms and county jails on issues related to consumers with behavioral health needs. The local providers educate these responders on the needs of consumers as well as on the services available through their agencies. In particular, in areas that are more rural, provider staff develops relationships with local hospital emergency rooms and other responders to keep them apprised of the unique needs of persons with mental illness and serious emotional disturbance in emergency situations. In the more

metropolitan regions, the providers sometimes contract with outside vendors to do training of emergency personnel.

Behavioral Health Link provides information and marketing materials regarding the Georgia Crisis and Access Line to hospital emergency room personnel and local law enforcement staff. The intent is for all emergency services personnel to be informed of the availability and process for accessing 24/7 crisis response for any individuals in a crisis related to mental illness or addictive diseases.

In September of 2016, Governor Nathan Deal announced a law enforcement reform package that includes a multi-phase overhaul of officer training and certification courses. The reform package includes enhanced resources for Georgia Crisis Intervention Team (CIT) and a provision that will involve the transfer of CIT to the Georgia Public Safety Training Center (GPSTC), thereby streamlining training requirements and increasing access to more than 57,000 state and local officers. DBHDD now blends funds with GPSTC, to provide CIT training to Georgia's law enforcement officers using a curriculum that blends best evidence based practices from the new Bureau of Justice Assistance (BJA) CIT Model, the Memphis, Tennessee CIT model, and data gained from CIT practice in the field since 2006 In an effort to reduce the stigma associated with mental illness, the Georgia CIT Program's vision is a Georgia where citizens with serious mental illness receive medical treatment in lieu of incarceration. Georgia adopted a top-down approach to training law enforcement by forming a collaborative with executives from key departments of state government, mental health providers and advocacy organizations.

From FY06 through FY17, the CIT (Crisis Intervention Team) Program collaboration between NAMI Georgia and DBHDD trained police officers across the state to divert consumers from incarceration and link them to treatment services. In FY 17, 55 CIT trainings were conducted reaching more than 1,000 law enforcement officers. In addition, in FY17, DBHDD's OCYF, entered a separate contract with NAMI Georgia, to provide CIT for Youth Training. In general, CIT for Youth programs train officers on adolescent brain development and how mental health symptoms manifest with youth. Children and youth express their distress differently than adults and often respond to different styles of interaction. In addition, the training helps officers and school staff work to better address mental health concerns in a school setting. CIT for Youth programs teach law enforcement officers to connect youth with mental health needs to effective services and supports in their community. The goal is to intervene early in emerging mental health issues and prevent youth from becoming involved in the juvenile justice system. The programs work with schools, school-based police officers, children's mental health providers and parents to accomplish these goals.

During 2017, NAMI held several stakeholder meetings with over 175 stakeholders in Region 3 (Albany State University), Region 4 (Albany), and Region 5 (Savannah & Vidalia) to identify the barriers schools have connecting their students and resources available for them. Over 100

participants were trained on the CIT-Y, which included Atlanta Public Schools Police Department and Albany Police Department as well as a Train the Trainer training to the Atlanta Public School Department of Education.

In response to requests from local law enforcement agencies wanting to increase their numbers of officers with at least some knowledge of behavioral health issues and response prior to their being able to attend the full week-long CIT course, NAMI facilitated a new DBHDD-funded Introduction to Behavioral Health Crisis curriculum--seven (7) 16-hour courses for Law Enforcement Officers waiting to attend the 40-hour CIT class, and eight (8) 8-hour courses for First Responders and 911 Operators— The goal and objective of the new **training** is to provide an in-service introductory course on behavioral health crisis for law enforcement officers as a precursor to the Georgia CIT Program. Components of the new class include:

1. An introduction to signs and symptoms of the behavioral health disorders law enforcement officers are most likely to see during their day-to-day encounters with citizens experiencing behavioral health crisis, disorders such as Depression, Bipolar Disorder, Post Traumatic Stress, Schizophrenia and Autism.
2. Statistics on the prevalence of mental illness, including information on incarceration rates, suicide, homelessness, recovery success rates, and the impact of stigma.
3. A basic overview on Legal Issues highlighting some of the Official Codes of Georgia relative to 1013, Probate Orders (OTA), transports, immunity, HIPPA, case law citing deliberate indifference, and Georgia Accountability Courts.
4. Community resources including information on the Department of Behavioral Health and Developmental Disabilities (DBHDD), Behavioral Health Link (BHL), Community Service Boards (CSBs), Advocacy and Recovery organizations such as National Alliance on Mental Illness (NAMI), Georgia Mental Health Consumer Network (GMHCN), Georgia Parent Support Network (GPSN), and the Georgia Council on Substance Abuse
5. Consumer Perspective featuring an "In Our Own Voice" presentation by a person living in recovery with mental illness. The presenter shares dark days of mental illness, acceptance, treatment, success hopes and dreams.
6. The last module will be an introduction to CIT, citing the history of CIT, benefits of CIT training, successful CIT outcomes, and skills taught during the course.

The state's Crisis Intervention Team Training Manual states that one of the main collaborative objectives between the GBI and NAMI is to "Ensure that people with mental illnesses and other brain disorders always receive treatment, in lieu of incarceration in most cases."

The Georgia Bureau of Investigation (GBI) has incorporated a module on trauma into its monthly training for new Crisis Intervention Team (CIT) State Patrol officers across the state. The training includes interviews with actual consumers who have received services for PTSD, education on the signs and symptoms of trauma and other mental illnesses, as well as de-escalation techniques for use in working with persons in crisis related to trauma. A goal of the CIT training program is that officers understand that involvement in many infractions of the law

may be a result of a person's trauma history or failure to receive proper trauma-informed treatment, rather than a result of intentional wrongdoing.

The FY18 transition of CIT to GPSTC will allow for expansion of CIT training to at least double the number of officers reached in previous years, and will allow for development of "CIT University". New online training modules will be developed to provide advanced add-on training for CIT certified officers. Modules may include trauma, similar to the current GBI module, Alzheimers and Dementia, veterans, youth in crisis, autism, and other topics designed to increase officers' knowledge and improve responses in the field.

DBHDD's Assistant Director of Adult Mental Health Services is the Program Manager for the GPSTC contract and is a member of the GPSTC Crisis Intervention Team Training Advisory Board.

Disaster Preparedness

DBHDD has a Disaster Mental Health Coordinator's (DMHC) position which is fully funded by the Georgia Department of Public Health. DBHDD's DMHC works with the Georgia Emergency Management Agency and other emergency preparedness agencies to ensure that the behavioral health needs of Georgia residents are included in state-level plans by participating in numerous workgroups and task forces. The DBHDD Regional Hospitals and provider agencies are members of Regional Emergency Preparedness Healthcare Coalitions throughout the state and they participate in exercises with local healthcare and emergency preparedness partners. ACT, CST, ICM, CM, and SE providers receive training in continuity of operations and personal disaster planning as well as training on how to work with individuals to develop a personal disaster plan. Georgia's disaster mental health website at www.georgiadisaster.info contains information and resources on disaster mental health planning. Training in disaster preparedness is available for providers. DBHDD has a continuity of operations plan policy for its state office and policy that requires continuity of operations for all contracted providers. Disaster mental health training and exercises takes place throughout the state several times a year.

Staffing Issues

Community mental health services in Georgia are provided through a number of contracted public and private provider agencies. These are not state agencies and therefore we do not have specific knowledge about the numbers of staff of differing professional disciplines that are employed by each agency. Staffing requirements for services within the Georgia mental health system are established in both the *Provider Manual for DBHDD Community Mental Health Providers* and the Medicaid Services Manual.

Practitioners are divided into professional and paraprofessional categories, and licensed mental health professionals practice under the scope of relevant practice laws. Paraprofessionals are

those practitioners who are not licensed or certified to practice independently. All paraprofessionals as aforementioned must complete standardized training. Each service definition contains specific staffing patterns that include the required level of supervision by a licensed practitioner, as well as staff to consumer ratios that meet standards of care. Urban areas of the state generally have more access to all categories of professional staff. Recruiting and retaining qualified staff presents a continuous challenge to rural providers. There is a shortage of Child Psychiatrists and psychiatric nurses in Georgia. Nurses and social workers are also under-represented within the public mental health system, causing providers to focus significant resources on recruitment and retention activities. While shortages of all levels of professional staff exist within the Georgia system, concerted efforts are made to secure qualified staff for services provision.

According to the Georgia Composite Board there are 6,800 Professional Counselors; 872 Marriage and Family Therapists; 3,878 licensed Clinical Social Workers; 2, 732 licensed master's level Social Workers; 114 Associate Marriage and Family Therapists; 1,454 Associate Professional Counselors; and 2,382 Licensed Psychologists. Many rural counties report lack of child and adolescent psychiatry services. In addition, in looking at recent graduates in 2017 from the University System of Georgia, there were 354 graduates in Social Work; 40 graduates in Marriage and family Therapy; 12 graduates in Psychiatric Nursing; 3237 graduates in School Counseling; and 9 graduates in Clinical Psychology.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

UNMET SERVICE NEEDS AND PLANS

Georgia is the 24th largest geographic state and the eighth most populous state in the Nation. Georgia is a microcosm of the nation culturally, racially, and ethnically. Its diversity includes mountainous regions, rural farming communities, heavily populated urban centers, and a coastal region with a significant senior population. With 159 counties, Georgia's land mass is over 57,000 square miles with 168 persons living per square mile. The distance from the Northern part of the state, the mountainous region, to the southern part of the state, the coastal plain, is 300 miles. And as the eighth most populous state, Georgia's population has grown 8.6% from 2010 to 2018, increasing from 9,688,681 to 10,519,475. At its current growth rate, Georgia's population will exceed 14 million in the next 20 years.

Four counties, all located in the core counties of metro Atlanta, account for almost 3.5 million (33%) of the state's 10.5 million population. Of the remaining 155 counties, 26 counties are in the 300,000 to 100,000 population range, 32 are in the 99,000 to 30,000 range, and 97 have populations of less than 30,000 (including 33 counties with populations of less than 10,000).

According to the 2018 U.S. Census estimates, of the state's 10.5 million residents, 60.52% were white, 32.4% African American or black, 4.3% Asian, .5% American Indian or Alaska Native, 2.2% two or more races, and 9.8% were Hispanic/ Latino. Foreign born persons represent 10.0% of the population and 13.9% of the state's residents speak a language other than English at home.

With respect to age, Georgia's population continues to be younger compared to the U.S. as a whole, ranking 4th in the percentage with the largest population under 18 years old. Persons under 5 years of age represent 6.2% of the population, children and youth under 18 years 23.8%, persons ages 18 to 64 62.3%, and persons age 65 and above 13.9%. Females represent 51.4% of the state's population. Sexual orientation data is not available for Georgia.

For education and income, U.S. Census data indicate that 86.3% of persons age 25 and older (2013-2017) are high school graduates and 29.9% have a bachelor's degree or higher. Georgia's 2013-2017 median household income was below the national average at $52,977 compared to $57,662 nationally. The percentage of people below the federal poverty level (2013-2017) is higher than the U.S., 14.9% versus 12.3%. Georgia's unemployment rate has improved significantly over the last four years, decreasing from 7.3% in July 2015 to 3.7% in July 2019. Although in years past, the state's rate was higher than the U.S. as a whole, Georgia's rate is currently the same as that of the whole nation.

Georgia uses the federally-run health insurance exchange. During the open enrollment period for 2019 coverage, enrollment in private plans through the Georgia exchange totaled over 460,000, representing about a 20,000 decrease in enrollment from the previous year.

A significant number of Georgians remain uninsured because they are not eligible for the state's federally run exchange or are ineligible for Medicaid. Georgia has chosen not to expand Medicaid. The Georgia Department of Community Health (DCH), designated as the state agency for Medicaid and PeachCare for Kids®, provided access to health care for nearly 2 million low income children, pregnant women, and people who are aging, blind and disabled. Under current

eligibility requirements single childless adults do not have access to Medicaid benefits. DCH also administered the State Health Benefit Plan (SHBP), providing health care coverage for 661,165 state employees, public school personnel, retirees and dependents as of June 2018. Combined, these two divisions provided health insurance coverage to approximately one in four people in the state, or more than 2.6 million Georgians.

Access to care for Georgians with behavioral health issues is impacted by the large number of rural counties in the state and the lack of transportation outside of metro areas. Nearly half of the state's residents live in rural areas. These areas have no public transportation and individuals without access to a car have difficulties accessing care, including behavioral health care.

A unifying condition for virtually all of Georgia's homeless population is poverty. Many people who are homeless also experience some type of personal vulnerability that places them at risk, such as: family violence, physical disability or chronic medical problems, mental illness, substance abuse, and developmental disability or brain injury. (DCA 2015 Report on Homelessness)

A Department of Community Affairs Balance of State Continuum of Care (BoS CoC) Point in Time survey conducted in January 2017, which covered 152 of Georgia's 159 counties, determined that 3,176 people were literally homeless. This represents a 36% decrease from 2015. Of those 3,176 persons, 1,843 were unsheltered and 1,873 were sheltered.

Fifty-five percent of the total homeless population in the 2017 BoS CoC survey is male; however, that percentage does differ when it is broken down by homeless status. Men are more commonly experiencing unsheltered homelessness. This could be skewed due to the fact that there are more shelters in the BoS that serve predominantly female victims of domestic violence, than there are shelters that serve men specifically.

The majority of the CoC's homeless population identifies as Black or African American. Six percent identify as Hispanic or Latino. Children under the age of 18 comprise 23% of the homeless population, and 8% are between the ages of 18 and 24.

People with special needs are the most vulnerable subset of the homeless population. According to the data collected for the 2017 Point in Time survey count, 6.5% of people experiencing homelessness are chronically homeless, meaning that they have a disability and have been homeless for at least one year, or four times in the past three years. Four percent of the homeless population observed in January of 2017 were veterans. Almost 12% (373) were persons with had mental health issues and about 16% (496) were individuals with substance use disorders.

Data from a count conducted in January 2017 by all nine of Georgia's homeless program regions (Continua of Care) and that covers all 159 counties showed that on the day of the survey at least 10,373 people were literally homeless in the state. This count represents a 25% decrease from 2015.

There are several homeless subpopulations that HUD is tasking CoCs with prioritizing, two of which are veterans and chronically homeless. Seven percent (7%) of the homeless population in

Georgia on the night of the count were veterans. Ten percent (10%) of the homeless population was experiencing chronic homelessness on the night of the count. Chronic homelessness is defined as someone experiencing continuous homelessness for at least one year or at least four times in the past three years with their total time in shelters or on the street adding up to over one year and who has a disabling condition.

Source: Georgia Department of Community Affairs 2017 Report on Homelessness; Georgia Department of Community Affairs Georgia's 10,000 2017 Report on Homelessness.

Military Veterans

Georgia has a ten military bases and installations and it is estimated that Georgia has over 100,000 military and National Guard personnel. (About.com US Military Major Bases and Installations). In addition, Georgia has a large number of veterans living in the state. According to US Census data, Georgia has over 690,000 veterans. Many veterans are able to leave the military service and re-integrate into the community without significant problems. They are able to find work, start or continue their education, and reunite with their families. National and regional research indicates, however, that in the post 9/11 era there are increasing number of veterans who have difficulties after leaving military service, particularly those who served in combat and/or had multiple tours of duty in Iraq or Afghanistan with short time between redeployments.

Veterans face a number of re-integration challenges, including the behavioral adaptations that may be required in moving from a highly structured life in the military to civilian life. Those who served in combat conditions particularly may face difficult transitions, ranging from losing the strong bonds developed with their colleagues to post traumatic stress disorder (PTSD) to mental and/or physical health disabilities. They may also have difficulties in re-establishing family ties that can provide them with support. "When soldiers are not well reintegrated into society, they can face severe challenges. Some of the most crippling of those challenges are unemployment, mental and physical disabilities, and homelessness." (Georgia Center for Nonprofits, Metro Atlanta Veterans Services Report, 2012) Further, data has shown that veterans are at increased risk of suicide. Although data is limited, according to the US Department of Veterans Affairs, in 2016 in Georgia there were 202 suicides with a rate of 28.9 among veterans compared to 1,352 suicides among the general population and a rate of 17.4.

The families of military and veteran personnel also face challenges. The stress of military life including deployment (of the military veteran alone as well as family moves to new military assignments) can impact family members as well. Reintegration of the military member (particularly those with trauma related issues) into the family after deployment can also affect other family members.

Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Community

Data on the number of LGBTQ individuals nationally as well as in Georgia is very limited. The Williams Institute estimates that less 10% (estimates vary) of adults in the U.S. identify as lesbian, gay or bisexual and that approximately 0.3% of adults are transgender. Members of the LGBTQ community often face a number of challenges including homophobia, stigma, discrimination, family and community acceptance, and health disparities (including mental

health and drug use).

Although data is limited, statistics regarding LGBTQ youth are particularly of concern. A CDC study has shown that LGBTQ youth represent 20-40% of homeless youth, 19% of child welfare youth, and 20% of juvenile justice system youth. In addition, they are three times as likely to be bullied at school, three times as likely not to go to school because of not feeling safe, and three times as likely to be sexually assaulted. LGBT youth are four times more likely to attempt suicide than straight peers and questioning youth are three times more likely. In addition, "suicide attempts by LGBT and questioning youth are four to six times more likely to result in injury, poisoning, or overdose that requires treatment from a doctor or nurse, compared to their straight peers". It is also alarming that almost half of transgender youth have "seriously thought about taking their lives, and one quarter report having made a suicide attempt". Research has also shown that LGB youth who "come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection". It has been shown that each episode of LGBT victimization (i.e., physical or verbal harassment or abuse) increases the chances of self-harming by 2.5 times on average. (The Trevor Project)

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), the Single State Authority for Mental Health, provides behavioral health services for low income uninsured and underinsured Georgians.

ADULT MENTAL HEALTH-UNMET NEED

According to the Behavioral Health Barometer, Georgia 2015 there has been an increase in the percent of SMI among adults from 3.7% in 2012 to 4% in 2015. The annual average percentage in 2014-2015 (4%) was similar to the corresponding national annual average percentage (4.1%). In addition, the percentage of mental health treatment among adults with any mental illness indicated that 37.4% received treatment and 62.6% did not receive treatment in 2014-2015. Out of the adults who received treatment 73,5% reported improved functioning compared to 71.8% in the nation as a whole.

In the Mental Health America Report, *The State of Mental Health in America 2019*, Georgia is ranked 21st overall in terms of prevalence of mental illness and compared to other states based on the 15 measures of which 7 are related to adult mental health. These seven measures and their rankings are:

1. Adults with Any Mental Illness-17th (2017 – 22nd)
2. Adults with Dependence or Abuse of Illicit Drugs or Alcohol- 4th (2017 - 12th)
3. Adults with Serious Thoughts of Suicide- 18th (2017 - 22nd)
4. Adults with AMI who Did Not Receive Treatment-42nd (2017 - 46th)
5. Adults with AMI Reporting Unmet Need- 27th (2017 - 18th)
6. Adults with AMI who are Uninsured-47th (2017 - 46th)
7. Adults with Disability Who Could Not See a Doctor Due to Costs-46th (2017 - 51st)

The overall ranking of Georgia on all seven adult measures was 31st, up from 40th in 2017

Data in the Georgia 2018 Uniform Reporting System (URS) tables indicate that 5.5% of those served received supported housing services; 2.9% received supported employment services; and, 3.2% received assertive community treatment services. Additional data indicated that among adults served in Georgia's public mental health system in FY18, 52.9 were not in the labor force. Also, 72.7% of adults reported improved functioning from treatment received in the public mental health system compared to 76.6% on average in the U.S and 70.6% median score.

Georgia's plans for system capacity and service development to meet adult mental health needs in the community are based on federal estimates of prevalence of serious mental illness in the population aged 18 and older. Prevalence tables are constructed annually for each DBHDD region based on county population figures for each county in the region. Georgia's 2017 estimated resident population for persons above 18 years of age is 7,467,887. Using the CMHS prevalence estimate of 5.4%, Georgia has an estimated 403,266 adults with SMI. In FY17, DBHDD served 122,183 consumers with SMI which was 30.3% of the overall need. Prevalence data has always been limited as a true measure of effectiveness of access and outreach efforts since consumers with benefits have access to services other than those provided by DBHDD. This is further complicated by the fact that the DBHDD now provides benefits only to those adults with no other funding source and to those receiving Medicaid benefits through the Aged, Blind and Disabled program. Other consumers living with serious mental illness may be served through Care Management Organizations (CMOs); thus, analysis of how many persons should be served through DBHDD is less clear than in previous years. Given this, DBHDD targets those adults 18 and over under 200% of poverty. The estimated number of adult consumers who need services from the public sector using this factor is 134,683 (33.4%). The percent of estimated eligible mental health need reached was 90.7%.
According to the 2018 Georgia URS Tables, DBHDD served 137,169 individuals in all Mental Health Programs. Of this number, 89% were adults ages 18 years and over. For all adults served, 11% were young adults ages 18-24 years old; 74% were adults ages 25-64 years old; 3% were older adults ages 65-74; and .5% adults over 75 years old. The breakdown of those served by race/ethnicity is; 50% were White; 43% were Black or African American; 4% were Hispanic or Latino; 1.4% were Asian; .2% were American Indian or Alaska Native; .2% were Native Hawaiian or Another Pacific Islander; and, 1.4% reported more than one race.

The data by gender indicates that 51.3% females (52.4%) and 48.7%) males were served.

In FY18, 137,169 consumers were served in the community representing 97% of all those served. In FY18, 3,576 adults were served in State Operated Psychiatric Hospitals compared to 4,309 in FY16. This represents a decrease of adults served in State Operated Psychiatric Hospitals. In FY16, the readmission rates for civil and voluntary admissions were 7.2% and 18.6% for 30 day and 180-day readmissions respectively. In FY18, the readmission rates for civil and voluntary admissions were 4.1% and 14.4% for 30 day and 180-day readmissions respectively, a considerable decrease.

Data gathered from the Information System indicate that 108,406 adults received Core Services in SFY19, 13,387 received Crisis Stabilization Unit services; 3,330 received Peer Support services; 1,652 received Psychosocial Rehabilitation group services; 3,049 received Supported Employment; and 2,529 received Assertive Community Treatment.

DBHDD utilizes a definition to identify adults who are eligible to receive public sector mental health services. This definition incorporates the elements of the federal definition for SMI and also sets diagnostic and functional criteria to identify eligibility for brief intervention for individuals who do not necessarily meet the SMI definition. "Priority Populations" define the individuals who are to be served with the public benefit.

There are four variables for consideration to determine whether an individual qualifies as a "Core Customer" for adult mental health and addictive disease services:

1. **Age:** An individual must be over the age of 18 years old. Individuals under age 18 may be served in adult services if they are emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated.
2. **Diagnostic Evaluation:** The DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify an individual's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports a psychiatric disorder and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnostic impression/diagnosis.
3. **Functional/Risk Assessment:** Information gathered to evaluate an individual's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. This includes the individual's resource utilization, role performance, social and behavioral skills, cognitive skills, communication skills, independent living skills, personal strengths and adaptive skills, needs and risks as related to a psychiatric disorder, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.
4. **Financial Eligibility:** Established in DBHDD policy: The following individuals receive priority for ongoing treatment and support services:

   a. Individuals transitioning into the community from a state operated psychiatric facility (including forensic individuals), state funded/paid inpatient services, a crisis stabilization unit, behavioral health crisis center or intensive residential program.
   b. Individuals with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
   c. Individuals with a history of one or more crisis stabilization unit/behavioral health crisis center admissions within the past 3 years;
   d. Individuals with behavioral health needs who are criminal justice system involved, including those who are; court ordered to receive behavioral health services, under the correctional community supervision with mental illness or substance use disorder or dependence, released from secure custody (county/city jails, state prisons, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;

e. Individuals aging out of out of home placements or who are transitioning from intensive C&A services, for whom adult services are clinically and developmentally appropriate.
f. Individuals who are chronically homeless with behavioral health needs

Data to support planning and to monitor service effectiveness is collected through several processes. The contracted ERO collects and reports consumer encounter data that includes information on consumer level of need and response to treatment. When originally developed, this ERO data was only generated for Medicaid eligible consumers, which represents approximately half of the adults served in the public mental health system. Under the existing ERO contract this data is collected and reported for all consumers in service within the public mental health system, regardless of payer source. System evaluation information is collected with consumer surveys and clinical functional assessment tools. The consumer survey that is employed is administered consumer-to-consumer and utilizes the questions of the national MHSIP survey. The clinical functional assessment data is collected through the ERO function.

As indicated previously, the DBHDD system of services is administered through six Field Offices. These offices administer the hospital and community resources assigned to the region. They oversee statewide initiatives; develop new services and expand existing services as needed; and, monitor the services being received by consumers to ensure quality and access. Service planning is unique to the needs of each community and includes significant input from community members and service recipients. These offices have established Regional Collaboratives in their regions with representatives from provider agencies, advocacy groups, and other key stakeholders. These RCCs provide valuable information to the Field Offices related to service delivery. In addition, the Field Offices work collaboratively with established Regional Advisory Councils. These Councils are composed of community citizens appointed by their county Commissioners. Additional data on gaps and services by DBHDD Regions has been reported in the 2017-2018 DBHDD Statewide and Regional Priorities and Key Strategies document developed by the DBHDD Statewide Leadership Council which is composed of the Chairs of the 6 Regional Advisory Councils along with the entire RAC membership. The recommendations in the report are the result of a 20- month comprehensive community input and priority process conducted across the state and within each region. Below is demographic information on each region as well as information gathered through the RAC process above.

Region One

Region One's 31 counties span the width of North Georgia and have a total estimated adult population of 1,910,229 people representing 26.2% of the total adult population. Based on Federal
Center for Mental Health Services (CMHS) estimating methodology of 5.4% of the total adult population having a serious mental illness (SMI), there are approximately 103,152 adults with SMI. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 32,699 adults with SMI could be considered public sector consumers. In FY 16, DBHDD adult mental health contracted providers for Region 1 delivered one or more services to 24,076 individuals needing public sector services representing 73.6% of the need reached.

The Adult Core Services Package is provided under contract by five Community Service Boards (CSBs), now called Tier 1, Comprehensive Community Providers (CCPs) or Safety Net providers, one County Board of Health, and by one private provider (now both called Tier 2 plus). There are an additional 9 Tier 2 or Community Medicaid Providers (CMPs), approved to provide Adult Core services in Region 1. These providers may bill Medicaid or private insurance, but do not receive any state funds. In addition, there are 8 Tier 3 Providers, which are Specialty providers. Some of the services other than core services (traditional outpatient) provided by Region 1 providers are: Peer Supports, Peer Recovery Center, Specialty Courts, Community Support Team (CST), Case Management, ACT, Crisis Respite Apartments, Intensive Case Management, Supported Employment, Behavioral Health Crisis Center, Crisis Stabilization Unit, Crisis/Transitional Housing, Mobile Crisis, Inpatient Psychiatric Services, PATH, Supported Housing and Community Residential Rehabilitation. In SFY16, 22,521 individuals received core services; 1,563 received crisis stabilization unit services; 794 received peer support services; 98 received psychosocial rehabilitation group services; 392 individuals received supported employment services; and, 446 individuals received ACT services.

Some of the priority needs and key strategies related to adult mental health for Region 1 recommended in the 2017-2018 RAC Report are:

- Reduce inappropriate involvement in the justice system by persons with mental illness, intellectual/developmental disabilities, and/or substance abuse.
    - Training for first responders to improve responses to people in crisis
    - Reduce recidivism rates through accountability courts
- Increase availability and enhance residential care for individuals with intellectual/developmental disabilities, mental illness, and or addictive diseases which would foster safe, comfortable home environments.
- Review and revise standards for staffing credentials and improve training to better meet the needs of individuals served.
- Improve access to and navigation of DBHDD services.
- Improve public understanding of the system and how to engage in services.
- Increase availability of peer supports to help people stay engaged in services.

Region Two

Region 2 is comprised of 33 counties covering 12,214 square miles with a total estimated adult population of 939,417 representing 12.9% of the total adult population in the state. Based on Federal Center for Mental Health Services (CMHS) estimating methodology of 5.4% of the total adult population having a serious mental illness (SMI), there are an estimated 50,729 adults with SMI. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 20,088 adults with SMI could be considered public sector consumers. In FY16, DBHDD adult mental health contracted providers for Region 2 delivered one or more services to 21,207 individuals needing public sector services representing 105.6% of the need.

The adult core services package is provided under contract by 5 Tier 1 providers (CCPs) receiving state funding to serve adults with behavioral health needs. There are also 8 Tier 2 providers (CMPs) and 7 Tier 3 Specialty providers. In addition to Core Services, there are other

services available: Case Management, Intensive Case Management, Community Support Team, ACT, Psychosocial Rehabilitation, Peer Support, Supported Employment, Crisis Stabilization Unit, Crisis Service Center, Crisis Respite Apartments, Mobile Crisis, Inpatient Psychiatric Services, Supported Housing and Community Residential Rehabilitation, PATH, and MH courts. In SFY16, 20,778 individuals received core services; 1,625 received crisis stabilization unit services; 415 received peer support services; 150 received psychosocial rehabilitation group services; 471 received supported employment services; and, 382 received ACT services.

Some of the priority needs and key strategies related to adult mental health for Region 2 recommended in the 2017-2018 RAC Report are:

- Establish a quality provider for Intellectual/Developmental Disabilities /Behavioral Health dual diagnosis including emergency and long-term residential services.
- Identify an evidence-based dual diagnosis treatment model
- Incentivize providers who are capable and interested
- Provide training for sustainability
- Identify funding sources
- Improve coordination among state agencies including Department of Family and Children's Services, Social Security, Department of Aging, and DBHDD.
- Identify which state agencies work with the target population.
- Create memoranda of understanding between state departments
- Create work groups to create solutions to barriers.
- Educate the public on desired outcomes
- Develop a comprehensive data management system that identifies current provider availability along with current placement needs.
- Identify current providers and capacity.
- Use Beacon system to identify how many individuals are being served in various programs
- Create a triage system
- Create a communication map of services delivered by each provider and provide to key stakeholders

Region Three

Region 3 is comprised of six metropolitan counties: Clayton, DeKalb, Fulton, Gwinnett, Newton and Rockdale and includes the capitol city of Atlanta. The total adult population of the region is 2,197,961 representing 30% of the adult population in the state. Using prevalence data, the number of adults with serious mental illness estimated to need treatment, residing in Region 3 is 118,690, or 5.4% of the total adult population. During FY16, 26,512 adults received behavioral health services from the provider network in Region 3. This number represents 23.3% of the estimated total need without factoring in eligibility for public sector services. Factoring in poverty, the estimated number needing services would be 39,168 representing 67.7% of the need reached.

There are 89 providers: 3 Tier 1 (CCPs), 54 Tier 2 (CMPs), 5 Tier 2+ and 27 Tier 3 Specialty providers. Services provided are Core, Case Management, ACT, ICM, Supported Housing and Community Residential Rehabilitation, Supported Employment, Crisis Respite Apartments,

Behavioral Health Crisis Center, Crisis Stabilization Unit, Mobile Crisis, Peer Support and Wellness, PATH, and MH Treatment Court Services. In addition, Region 3 is home to a provider for the Latino population, CETPA. In SFY16, 24,023 individuals received core services; 1,285 individuals received crisis stabilization unit services; 854 received peer support services; 734 received psychosocial rehabilitation group services; 467 received supported employment services; and 1,216 received ACT services.

The priority needs and key strategies related to adult mental health for Region 3 recommended in the 2017-2018 RAC Report are:

- Increase community awareness of DBHDD diagnosis and treatment services.
- Improve collaboration, communication, and education among all facets of the Criminal Justice Systems.

Region Four

Region 4 is comprised of 24 counties and is in the far Southwest corner of Georgia, bordering Southeast Alabama and North Florida. Region 4 is the smallest of the 6 Regions; however, the geographic area is 9,320 square miles, most of which is rural. The adult population is 438,911 representing 6% of the total adult population. Based on CMHS prevalence estimates, there are 23,701 adults with SMI in the region. Providers in this region served 13,511 adults with SMI. This number represents 57% of the estimated total need without factoring in eligibility for public sector services. Factoring in poverty, the estimated number needing services would be 11,258 representing 120% of the need reached.

The Behavioral Health system is comprised of 3 Tier 1 providers (CCPs), 3 Tier 2 providers (CMPs) and 6 Tier 3 Specialty providers. The services provided include: Core, Assertive Community Treatment, Case Management, Community Inpatient/Detox, Community Support Team, Behavioral Health Crisis Centers, Crisis Respite Apartments, Supported Housing and Community Residential Rehabilitation, Intensive Case Management, Peer Supports, Psychosocial Rehabilitation, and Supported Employment. In SFY16, 13,167 individuals received core services; 1,361 received crisis stabilization unit services; 332 received peer support services; 163 received psychosocial rehabilitation services group; 283 received supported employment services; and, 365 received ACT services.

The priority needs and key strategies related to adult mental health for Region 4 recommended in the 2017-2018 RAC Report are:

- Improve the ease of access to outpatient treatment for behavioral health, addictive diseases, and intellectual developmental disabilities in rural areas.
- Fund and recruit professional counselors to assess and treat individuals
- Collect data for everyone served to include distance traveled, costs of reaching destination and rate convenience of service location

Region Five

Region 5 is in the southeast corner of Georgia; it has a land mass of 15,128 square miles and covers 26% of the state. The region includes 34 counties. Overall population density for the region is significantly smaller than the density of the State of Georgia. The adult population is 791,140, representing 10%

of the total adult population in the state. Based on prevalence estimates, there are 42,722 adults in the region with SMI. During FY 2016, the number of adult consumers with SMI served in the region was 15,862, representing 37.1% of the need. Factoring in poverty, the estimated number needing services would be 17,089 representing 92.8% of the need reached.

In Region 5 there are 4 Tier 1 providers (CCPs), 3 Tier 2 providers (CMPs), 1 Tier 2+ provider, and 5 Tier 3 Specialty providers. They provide core services, Assertive Community Treatment, Community Support Team, Case Management, Intensive Case Management, Mobile Crisis, Crisis Respite Apartments, Crisis Stabilization Units, Inpatient Psychiatric Services, Supported Housing and Community Residential Rehabilitation PATH and a specialized jail diversion program. In SFY16, 15,806 individuals received core services; 1,676 received crisis stabilization unit services; 556 received peer support services; 418 received psychosocial rehabilitation group services; 356 received supported employment services; and, 406 received ACT services.

The priority needs and key strategies related to adult mental health for Region 5 recommended in the 2017-2018 RAC Report are:

- Increase overall funding at state level for DBHDD services in Georgia.
- Launch campaigns to educate legislators about public mental health services and the need for increased funding to provide these services.
- Encourage Community Service Boards to meet with local elected officials in their catchment areas to work collaboratively and creatively to use local resources to meet needs.
- Address the need for additional crisis beds including crisis stabilization units and crisis respite apartments.
- Secure a new Behavioral Health Crisis Center.
- Investigate evidence-based treatment programs to reduce likelihood of re-hospitalization.
- Investigate structure treatment programs such as Clubhouse programs and supported employment programs.

Region Six

Region 6 ranks third in population among the six DBHDD regions and covers 9,822 square miles. Many residents live in rural areas. The total adult population is 1,000,777, which represents 13.7% of the total adult population in the state. Based on CMHS prevalence estimates, there are 54,042 adults with SMI. The number of adults served in the region by DBHDD providers was 17,603, representing 32.6% of the need. Factoring in poverty, the estimated number needing services would be 18,212 representing 96.7%% of the need reached.

In Region 6 there are 5 Tier 1 providers (CCPs), 8 Tier 2 providers (CMPs) and 5 Tier 3 Specialty providers. The services provided are Core Services, Community Support Team, Case Management, Crisis Respite Apartments, Psychosocial Rehabilitation, Peer Support, Supported Employment, Case Management and Intensive Case Management, ACT, Behavioral Health Crisis Center, CSU, Mobile Crisis, Inpatient Psychiatric Services, Supported Housing and Community Residential Rehabilitation. In SFY16, 15,026 individuals received core services; 903 received crisis stabilization unit services; 493 received peer support services; 363 received psychosocial rehabilitation group services; 413 received supported employment services; and,

300 received ACT services.

The priority needs and key strategies related to adult mental health for Region Six recommended in the 2017-2018 RAC Report are:

- Address critical staffing shortages and the need for specialty services by recruiting providers and expanding telemedicine, mobile medicine, and crisis intervention services
- Work with Community Service Boards and other providers to identify and assess critical staff shortages
- Share this information with key stakeholders
- Work with CSBs to identify and initiate creative recruitment such as partnering with colleges and nursing schools
- Address shortages in rural areas through telemedicine, mobile medicine and crisis intervention services.

ADULT MENTAL HEALTH-PLANS TO ADDRESS UNMET NEEDS

Based on information from the analysis of available data sources, Regional Advisory Councils recommendations, input from the Behavioral Health Planning and Advisory Council, and the overall strategic direction of the DBHDD, the following areas will be addressed in the 2018-2019 MHBG application.

Increase Permanent Supported Housing

As part of Georgia's agreement with the Department of Justice under the Americans with Disabilities Act, DBHDD operates a housing voucher program targeting persons with serious and persistent mental illness transitioning out of institutional settings and those who are chronically homeless. Georgia has now entered a Settlement Agreement Extension which includes requirements for Supported Housing. The Agreement Extension, which was signed in the fall of 2016 is scheduled to end 6/30/18. In response to the Settlement Agreement the Department implemented the Need for Supporting Housing Survey (NSH) to assess the need for supported housing for individuals meeting DOJ settlement criteria. Between May 2016 and August 8, 2017, 1,107 individuals have been surveyed, of that number, 48% (529) individuals were determined to need supported housing. DBHDD is currently partnering with state and local re-reentry initiatives to ensure that those with serious mental health needs being released from jails/prisons have access to community-based services and supported housing.

In FY08, the Department of Community Affairs (DCA) and DBHDD entered a partnership to expand the housing resources for homeless individuals and those with behavioral health disabilities. The two Departments have been working cooperatively to establish supported housing programs and assist eligible individuals in obtaining and maintaining safe, affordable, independent housing. DCA provides many financing programs to develop housing and DBHDD provides the services and supports needed to assist people in remaining in the communities of choice. DBHDD continues to strengthen partnerships that can increase the availability of permanent supported housing for those with serious mental illness who are homeless.

In FY 2017, DBHDD and DCA expanded their MOU and created a shared position, the Director of Supported Housing, to cooperatively advance the collective housing efforts of both agencies. In March of 2017, the Office of Adult Mental Health, created the Supported Housing Unit with three staff dedicated and under the direction of the Supported Housing Director. This unit will move forth the goals of supporting providers of both housing and residential services as well as meeting and sustaining the supported housing requirements of the Settlement Agreement Extension. This includes, increasing access to supported housing for our target population, maximizing state resources for supported housing for our target population, operationalizing a statewide unified referral process for supported housing, and continuing the work of oversight of the statewide supported housing need and choice survey. This unit will work in collaboration with the DBHDD and DCA regional field offices, community BH providers, hospitals, state and local agencies and law enforcement to support comprehensive implementation of strategies that will promote supported housing access statewide.

Housing has been identified as a needed resource in all the DBHDD regions. Under the Settlement Agreement, DBHDD is required to provide expanded and enhanced community services of which supported housing is one. DBHDD has housing as a priority with a focus on supporting recovery of adults in community settings. Tier 1 providers operate under 12 CCP Standards and these standards include access to housing. The FY20 MHBG application includes Permanent Supported Housing as a priority area.

Increase Employment

Employment is a significant recovery support. DBHDD contracts for Supported Employment (SE) statewide. In past years, because of significant increases in state and MHBG funding, DBHDD has increased the SE service capacity in recent years. In addition, the department has continued to implement provider training on evidence-based practice SE (EBP SE) also known as the Individual Placement & Support (IPS) Model.

DBHDD has continued working with the Georgia Vocational Rehabilitation Agency (GVRA), Vocational Rehabilitation program (VR) formerly with the GA Department of Labor. In May 2015, a revised MOU was signed by agency Commissioners to formalize the partnership and agreement to work in a more coordinated and efficient manner, in accordance with federal and state regulations to provide EBP SE services and support more individuals with SPMI in meeting their vocational and employment goals. DBHDD and GVRA/VR Regional and State Office staff have implemented the recommendations to amend and create policies and procedures that will facilitate fulfillment of these goals.

DBHDD has established a priority to increase the number of adults with SMI to obtain and maintain employment. DBHDD collects data on employment in competitive employment settings. The FY20 MHBG application includes a priority focus on obtaining and maintaining employment.

Increase Access to Services for Adults Involved with Criminal Justice

In 2013, the BHCC established an initiative to address the needs of persons transitioning from the correctional/justice system into the community and created a workgroup, co-chaired by the DBHDD Director of Adult Mental Health and the Department of Community Supervision

Reentry Director to examine the issues. Early outcomes are fostering inter-agency partnerships to address barriers and infrastructure challenges for persons in the criminal justice system. From this collaboration developed the Forensic Peer Mentor initiative which focuses on successful transition of persons with behavioral health needs from incarceration back into the community. DBHDD is involved in the Georgia Prison Reentry Initiative (GPRI). This collaboration brings partnering agencies together to address issues of service access and effective community transition for persons with a mental illness who are returning from the correctional system.

DBHDD has established a priority to increase access to behavioral health services for returning citizens/criminal justice involved individuals with behavioral health needs. The FY20 MHBG application includes a priority focus on this population including the provision of forensic peer services, family reunification counseling and Peer Support services, as well as referrals of the target population to community mental health services.

Increase Access to Services for Older Adults

In July 2014, DBHDD and the Division of Aging Services (DAS) entered an agreement with the Fuqua Center for Late-Life Depression, Emory University to strengthen Georgia's system of care for the growing older adult population with severe and persistent mental illnesses. Work guided by the MOU includes identification of unmet needs of this population and the development of applicable processes aimed at improving the state's capacity to care for Older Adults with Mental Illness. In FY18 this agreement has been extended to include The Carter Center. A staff member from DBHDD and DAS have time committed to this work.

DBHDD also participates in the Georgia Coalition on Older Adults and Behavioral Health (GCOABH). The GCOABH has led efforts to cross train the aging network and the public behavioral health system regarding both systems of care and how to access services.

DBHDD has developed priority areas and indicators to focus on older adults in this MHBG application. The focus will be to increase access to community mental health services for adults with SMI who are age 65 or older as well as provision of cross training for behavioral health providers.

Increase Access to Deaf Mental Health Services

It is Georgia's vision that all individuals, including individuals who are deaf, deaf-blind, or hard of hearing and utilize ASL as a preferred language, have easy access to linguistically accessible and culturally competent high-quality care that leads to a life of recovery and independence. To this end, DBHDD created the Office of Deaf Services (ODS). This office is working on the following priority areas:

- Identification of Individuals with Hearing Loss.
- Identification of Communication Preferences and Needs
- Workforce Development of Georgia Behavioral Health Interpreters (GaBHIs)
- Development of Statewide Community-Based Accessible Services
- Deaf Services Provider Training Series
- Promotion of Public Information Awareness and Community Outreach

DBHDD is committed to developing and implementing Communication Assessment Reports to support generally accepted professional standards regarding provision of reasonable accommodations to DBHDD services for individuals who are deaf. These standards include identifying reasonable accommodations needed to access DBHDD services. The Communication Assessment Report provides a determination of any communication limitations and the reasonable accommodations needed for the individual to access DBHDD services in accordance with the Americans with Disabilities Act. In addition, the 2014 Belton Consent Order requires Communication Assessments to be completed for Deaf Class Members in connection with their entering non-crisis services. Deaf Class Members are defined in the order as individuals identified as deaf, receiving state or (non-MCO) Medicaid funding, and receiving non-crisis outpatient therapy services.

To identify and track appropriate provision of reasonable accommodations to services and to maintain compliance with the Belton Consent Order, it is essential that the Office of Deaf Services completes a Communication Assessment Report on all individuals identified as deaf and receiving state or (non-MCO) Medicaid funding to determine the individual communication accommodations needed.

To support this priority area DBHDD ODS has implemented several strategies including but not limited to:

- Infrastructure development:
  - Development of a Deaf Services Management System to track individuals who are deaf and receiving DBHDD services.
  - Hiring and training three additional Communication Assessment Specialists.
- Systemic development
  - Publication of Policy 15-111: Provider Procedures for Referral and Reporting of Individuals with Hearing Loss, which obligates providers to report individuals who are deaf to the Office of Deaf Services to complete a Communication Assessment prior to intake where possible.
  - Publication of Policy 15-112: Communication Assessment-development of a communication assessment report to document communication preferences and service accommodation needs.
- Provider Education
  - Publication of Policy 15-114: Accessibility of Community Behavioral Health Services for Individuals who are Deaf and hard of Hearing
  - Mandatory Behavioral Health provider trainings on Policy 15-111, Policy 15-112, Policy 15-114 and ADA requirements as well as portions of the provider contract and provider manual that pertain to individuals who are deaf.
  - Deaf Specific Crisis training developed for crisis providers across the state.
  - Mandatory Deaf Services Awareness Training for community behavioral health providers (counselors, therapists, social workers, and case managers, those support professionals who schedule appointments) to better equip providers to deal with individuals who have a mental health need and who may seek to receive community behavioral health services.

- Presentations to various Behavioral Health providers and provider organizations at state, regional, and local levels to deliver education and clarification on reporting procedures and implementation of the Communication Assessment Report recommendations.

Increase Access to Community Mental Health Services

DBHDD has worked to assure uniformity of services throughout the state and to increase availability of community services particularly in rural areas by developing models such as Community Support Team, Mobile Crisis, Behavioral Health Crisis Centers and expanding the use of Peer Support across service modalities. DBHDD continues to focus on increasing access to community mental health services for adults with SMI.

There are mobile crisis teams in all six regions. As Georgia enhances community integration options for persons living with a diagnosis of a major mental illness, mobile crisis response services fulfill an important role in stabilizing and supporting persons in crisis while assisting them in choosing the right environment to overcome that crisis. DBHDD continues to look at specialized models for mobile crisis, particularly to address individuals with co-occurring mental health and developmental disabilities.

Telemedicine continues to be an emerging avenue for dealing with the shortage of physicians and other practitioners in rural areas and Georgia is exploring additional ways to promote the effective use of telemedicine into the system of care. There are over 60 DBHDD provider sites that are participating in the Global Partnership for Tele-Health. In addition, DBHDD is working with DCH to implement a phased in approach to tele-mental health services. Effective October 1, 2017, the state implemented policy which allows all behavioral health services to be provided via telemedicine for non-English speaking individuals accessing services delivered by a practitioner who speaks his/her language (includes American Sign Language). Also, LPCs and LMFTs have been added as practitioners who can provide diagnosis and assessment.

PATH funded services provide a statewide strategy to strengthen outreach and engagement activities designed to target the chronically homeless population. DBHDD values the team approach to case management and promotes outreach teams that go into the street, shelters and familiar homeless gathering locations. Peer Specialists with homeless experience are integral members of the teams, bringing their unique contributions that promote dignity, respect, acceptance, integration, and choice.

In the 2020 MHBG application, DBHDD has developed a priority area focused on access to community mental health services. The plan focuses on mobile crisis services, PATH services and tele-mental health services.

Increase Training to Providers

With the goal to help adults with SMI to attain and maintain recovery in their lives, it is necessary to provide training that will support the ability of providers and key partners to deliver services and supports needed. With DBHDD moving toward a recovery-oriented system of care, it is necessary to continue to provide opportunities for providers to understand recovery focused service delivery. In addition, providers have diverse populations to serve and need training on working with specific populations such as

veterans and individuals from the LGBT community. DBHDD has also noted an increase in the ethnic and racial diversity of the state and of the consumers served by DBHDD providers. There is a need to enhance the availability of trainings to assist providers with becoming more culturally competent to better meet the needs of the populations to be served.

DBHDD trains key partners in Mental Health First Aid (MHFA) as a strategy to promote consumer success in housing arrangements and Supported Employment. This training teaches first responders about mental illness and how to manage an emerging mental health crisis.

DBHDD has established a priority area of provision of diverse training to community adult mental health providers. The goal is to increase access to training focused on supporting the behavioral health of diverse populations of adults with SMI. The training topics will include: recovery focused service delivery; cultural and linguistic competency; behavioral health needs of veterans; behavioral health needs of those with criminal history; behavioral health needs of LGBT individuals; and, Mental Health First Aid.

CHILD AND ADOLESCENT MENTAL HEALTH – UNMET NEED

Based on the US Census Bureau, in 2018 Georgia was estimated to have a population of 10,519,475. Children and adolescents under the age of 18 represent 23.8% of the population. When the Annie E. Casey Foundation released its first ever KIDS COUNT state rankings of child and family well-being in 1990, Georgia ranked 48th. The Foundation's 2019 rankings show that Georgia has made significant gains in three of four KIDS COUNT domains – education, health, family and community. Georgia ranked 38th in overall child well-being, 34th in education, 34th in health, and 38th in family and community. However, the state ranks 40th in economic well-being with 28% of the state's children living in homes where no parent had full-time employment. Further, more than 21% (500,000 children) of Georgia's children live in poverty; a rate higher than it was in 1990. However, in 1990 13% of the state's children did not have health insurance coverage compared to 7% today.

Seven percent (an improvement from 10% in 2010) of Georgia's children do not have health insurance compared to 5% nationally. Approximately 221,000 children in the state lack insurance coverage. Georgia's Medicaid program provides health care for 1.82 million children, pregnant women and people who are aged, blind and disabled. The Department of Community Health administers the state's Medicaid and PeachCare for Kids State Child Health Insurance (CHIP) programs. Fifty-two percent (1,443,084) of Georgia's children 19 and under are covered by Medicaid or PeachCare for Kids. Almost 53% of the DCH budget is for Aged, Blind and Disabled (ABD) Medicaid and approximately 44% of the budget is for low-income Medicaid and 3% is for PeachCare for Kids. To qualify for PeachCare, the children must live in a home where the income is at or below 235% of the Federal Poverty level.

Georgia currently serves a monthly average of 1,862,573 Medicaid members (estimated 65% are children) and 127,975 Children's Health Insurance Plan members under PeachCare for Kids. Medicaid eligibility requirements allow for coverage for low income families, pregnant women, children and specified aged, blind, and disabled citizens. Under current eligibility

requirements single childless adults do not have access to Medicaid benefits.

In the Mental Health America Report, *The State of Mental Health in America 2019*, Georgia is ranked 21st compared to other states based on 15 measures of which 7 are related to child and adolescent mental health. These seven measures and their rankings are:

1. Youth with at least one past year major depressive episode (MDE)- 2nde (2017-8th)
2. Youth with dependence or abuse of illicit drugs or alcohol- 3rd (2017-13th)
3. Youth with severe MDE- 4th (2017-2nd)
4. Youth with MDE who did not receive mental health services- 16th (2017 -28th)
5. Youth with severe MDE who received some consistent treatment- 48th (2017-47th)
6. Children with private insurance that did not cover mental or emotional problems- 32nd (2017-38th)
7. Students identified with emotional disturbance for an Individualize Education Program – 28th (2017-24th)

States with high rankings have lower prevalence of mental illness and higher rates of access to care for youth. Lower rankings indicate that youth have higher prevalence of mental illness and lower rates of access to care.

Additional information related to mental health issues of youth in Georgia, is in the Behavioral Health Barometer, Georgia 2015 Report. In this report, the following is cited:

- An annual average of about 85,000 adolescents aged 12-17 in 2014-2015 had experienced a Major Depressive Episode (MDE) in the past year.
- An annual average of about 27,000 adolescents (40.3%) aged 12-17 with past year MDE from 2011-2015 received treatment for their depression in the past year.
- In 2015, 19,657 children and adolescents were served in Georgia's public mental health system. 45.8% of adolescents reporting improved functioning. This percentage was lower in Georgia than in the nation as a whole.

DBHDD provides services to youth with SED and their families. Georgia has been using the federal definition of SED as part of the eligibility criteria for services. According to the Center for Disease Control and Prevention, one in five youth in the United States have mental health conditions. According to the U.S. Census figures for 2016, there are 2,515,730 children and adolescents 0-17 in Georgia. Applying 20% to this total would yield 503,146 youth in Georgia with a mental health condition.

Further, estimation methodologies recommended for youth with SED were provided by the Center for Mental Health Services. These estimation methodologies identified two prevalence estimates, one of 5% - 9% for youth with SED and extreme functional impairment and one of 9%-13% for youth with SED and substantial functional impairment. These estimates are only applied to the 9-17-year-old age group. No estimation methodology has been provided by CMHS for estimating prevalence of emotional disturbance in children birth through age 9.

According to the Uniform Reporting System Tables provided by CMHS, Georgia would utilize

the 7%-9% range for determining prevalence of youth with SED and extreme functional impairment and 11%-13% range for determining prevalence of youth with SED and substantial functional impairment. Applying this percentage to the 2015 child and adolescent population of 1,246,332 age 9-17 years old would yield a prevalence range of 87,243 to 112,170 for youth with SED and extreme impairment and a prevalence range of 137,097 to 162,023 for youth with SED and substantial impairment. Due to limited resources, Georgia is targeting the youth with SED and extreme impairment utilizing an 8% prevalence rate which yields a target of 99,707. In SFY2015, DBHDD served 15,662 youth aged 9-17. Using this data and applying the prevalence estimate, DBHDD reached 15.6% of the estimated need. With 200% poverty as a factor, the estimated number of youth needing services from the public sector is 46,463. Using this factor, DBHDD reached 33.5% of the estimated eligible need.

According to the Georgia URS Tables for the 12/1/2016 Report Submission, DBHDD served 17,385 children and adolescents in community mental health programs, constituting 12.2% of all those served. In addition, according to this report, DBHDD served 10,660 children and adolescents with SED ages 0-17. No children were served in state psychiatric hospitals. It is also important to note that DBHDD does not serve all SED youth in need of services. Most youth are currently served by the DCH/Division of Medicaid Assistance through Care Management Organizations (CMOs). They serve youth in their parent's custody who are Medicaid eligible and youth who are involved with DFCS (not foster care) or committed DJJ youth who are Medicaid eligible. DBHDD serves uninsured youth, children receiving SSI and adoptive children whose families choose to opt out of the CMO. There are also youth with private insurance who receive services from private and public providers.

In SFY2016, 11,087 youth received Core Services. In addition, 1,235 youth received crisis stabilization unit (CSU) services; 10 youth received supported employment (SE) services, 881 children and adolescents received Intensive Family Intervention (IFI) services, and 198 (Medicaid only) received Psychiatric Residential Treatment Facility (PRTF) services. Since there are no longer child and adolescent state hospital units, DBHDD does not have state hospital admissions and readmissions data to report.

The most relevant strength of the DBHDD system is the development of the eligibility definition for child and adolescent mental health and addictive disease services. Because of growing pressure for services using the public dollar, it became imperative to identify those who are eligible to receive services, and the level of services to be offered. The following information on eligibility is included in the DBHDD 2018 Provider Manual. There are four variables for consideration to determine whether a youth qualifies as eligible for child and adolescent mental health and addictive disease services:

1. **Age:** A youth must be under the age of 18 years old. Youth aged 18-21 years (children still in high school or when it is otherwise developmentally/clinically indicated) may be served to assist with transitioning to adult services.

2. **Diagnostic Evaluation:** The DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify a youth's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports an emotional disturbance and/or substance related disorder primary diagnosis (or diagnostic impression). The diagnostic evaluation must be documented adequately to support the diagnosis.
3. **Functional/Risk Assessment:** Information gathered to evaluate a child/adolescent's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. This includes youth and family resource utilization and the youth's role performance, social and behavioral skills, cognitive skills, communication skills, personal strengths and adaptive skills, needs and risks as related to an emotional disturbance, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) in accordance with the DSM.

4. **Financial Eligibility:** Established in DBHDD policy.

The following youth are priority for services:

1. The first priority group for services is Youth:
   - Who are at risk of out-of-home placements; and
   - Who are currently in a psychiatric facility or a community-based crisis residential service including a crisis stabilization unit.
2. The second priority group for services is:
   - Youth with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
   - Youth with a history of one or more crisis stabilization unit admissions within the past 3 years;
   - Youth with a history of enrollment on an Intensive Family Intervention team within the past 3 years;
   - Youth with court orders to receive services;
   - Youth under the correctional community supervision with mental illness or substance use disorder or dependence;
   - Youth released from secure custody (county/city jails, state YDCs/RYDCs, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;
   - Pregnant youth;
   - Youth who are homeless; **or,**
   - IV drug Users.

Data to support planning and to monitor service effectiveness is collected through several processes. The contracted ERO collects and reports consumer encounter data that includes information on consumer level of need and response to treatment. When originally developed, this ERO data was only generated for Medicaid eligible consumers. Under the existing ERO contract this data is collected and reported for all consumers in service within the public mental

health system, regardless of payer source. System evaluation information is collected with consumer surveys and clinical functional assessment tools. The consumer survey that is employed is administered by families and utilizes the questions of the national MHSIP survey. The clinical functional assessment data is collected through the ERO function.

As indicated previously, the DBHDD system of services is administered through six Field Offices. These offices administer the community resources assigned to the region. They oversee statewide initiatives; develop new services and expand existing services as needed; and, monitor the services being received by consumers to ensure quality and access. Service planning is unique to the needs of each community and includes significant input from community members and service recipients. These offices have established Regional Collaboratives in their regions with representatives from provider agencies, advocacy groups, and other key stakeholders. These RCCs provide valuable information to the Field Offices related to service delivery. In addition, the Field Offices work collaboratively with established Regional Advisory Councils. These Councils are composed of community citizens appointed by their county Commissioners. Additional data on gaps and services by DBHDD Regions has been reported in the 2017-2018 DBHDD Statewide and Regional Priorities and Key Strategies document developed by the DBHDD Statewide Leadership Council which is composed of the Chairs of the 6 Regional Advisory Councils along with the entire RAC membership. The recommendations in the report are the result of a 20- month comprehensive community input and priority process conducted across the state and within each region.

Below is demographic information on each region as well as information gathered through the RAC process above.

Region One

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 1 had a child and adolescent population ages 9-17 of 336,391. Based on prevalence estimates there are approximately 26,911 youth with SED in Region 1. DBHDD providers in Region 1 served 2,927 youth age 9-17 in SFY15 meeting 10.9% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 8,531 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 1 reached 34.3% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetrations rates in the child and adolescent population are estimated to be much higher if these numbers were included.

Region 1 has a total of 24 child and adolescent providers covering 31 counties in the northern part of the state; 5 Tier 1 (CCPs), 10 Tier 2 (CMPs), 2 Tier 2+, and 7 Tier 3 Specialty providers. Many providers operate in multiple counties and most of the providers provide a majority of their services in the community versus a traditional clinic-based setting. This assists families

with transportation issues and scheduling barriers to be able to access needed services in their own homes. In SFY16, 2,412 youth received core services (traditional outpatient services), 241 received CSU services, 291 received IFI services, 1 received SE services, and 90 (Medicaid only) received PRTF services. In addition to these services, youth have access to C&A Specialty Services; Mobile Crisis, Care Management Entities, MH Clubhouses, School-based Mental Health Services, and System of Care Supplemental Funds.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 1 recommended in the 2017-2018 RAC Report are:

- Reduce inappropriate involvement in the justice system by persons with mental illness, intellectual/developmental disabilities, and /or substance abuse.
- Prevention/early intervention in elementary school populations.
- Training for first responders to improve responses to people in crisis.
- Improve access to and navigation of DBHDD services.
- Improve public understanding of the system and how to engage in services.
- Increase availability of peer supports to help people stay engaged in services.

Region Two

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 2 had a child and adolescent population ages 9-17 of 151,656. Based on prevalence estimates there are approximately 12,132 youth with SED in Region 2. DBHDD providers in Region 2 served 2,124 youth age 9-17 in SFY15 meeting 17.5% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 4,804 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 2 reached 44.2% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetrations rates in the child and adolescent population are estimated to be much higher if these numbers were included.

There are 18 child and adolescent providers serving 33 counties in Region 2: 5 Tier 1 (CCPs), 4 Tier 2 (CMPs), 6 Tier 3 Specialty providers and 1 CBAY provider. In addition to core services (traditional outpatient services), children, youth and their families have access to the following services: Mobile crisis, crisis stabilization units, structured residential supports, Care Management Entity services, Resiliency Support Clubhouses, Juvenile Mental Health Court, Psychiatric Residential Treatment Facilities and Inpatient Acute Psychiatric Treatment. In SFY16, 1,454 youth received core services, 272 received CSU services, 90 received IFI, and 15 (Medicaid only) received PRTF services.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 2 recommended in the 2017-2018 RAC Report are:

- ❖ Improve coordination among state agencies including Department of Family and Children's Services, Social Security, Department of Aging, and DBHDD.
- ➢ Identify which state agencies work with the target population.
- ➢ Create memoranda of understanding between state departments
- ➢ Create work groups to create solutions to barriers.
- ➢ Educate the public on desired outcomes
- ❖ Develop a comprehensive data management system that identifies current provider availability along with current placement needs.
- ➢ Identify current providers and capacity.
- ➢ Use Beacon system to identify how many individuals are being served in various programs
- ➢ Create a triage system
- ➢ Create a communication map of services delivered by each provider and provide to key stakeholders

Region Three

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 3 had a child and adolescent population ages 9-17 of 378,893. Based on prevalence estimates there are approximately 300,311 youth with SED in Region 3. DBHDD providers in Region 3 served 4,851 youth age 9-17 in SFY15 meeting 16% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 10,003 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 3 reached 48.5% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice
system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetration rates in the child and adolescent population are estimated to be much higher if these numbers were included.

There are 90 child and adolescent providers covering 6 counties in the metropolitan Atlanta area: 3 Tier 1 providers (CCPs), 63 Tier 2 providers (CMPs), 3 Tier 2+ providers and 21 Tier 3 Specialty providers. Other services provided are Intensive Family Intervention, structured residential supports, Resiliency Supports Clubhouses, school-based mental health services, CSU, Mobile Crisis, Care Management and PRTF. In FY16, 3,884 youth received core services, 321 received CSU services, 1 received Assertive Community Treatment services, 312 received IFI services, 1 received psychosocial rehabilitation services and 79 (Medicaid only) received PRTF services.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 3 recommended in the 2017-2018 RAC Report are:

- ❖ Increase community awareness of DBHDD diagnosis and treatment services.
- ➢ To identify children and adolescents in need of services from DBHDD, place a mental health professional in all county and city schools in Region 3.

- ❖ Develop services that address the needs of children and adolescents with behavioral health, intellectual/developmental disabilities, and addictive diseases.
- ➢ Develop more in-school counseling for behavioral health, intellectual/developmental disabilities, and addictive diseases.
- ➢ Develop step-down treatment programs which are therapeutic but less intensive than a Psychiatric Residential Treatment Facility and a Crisis Stabilization Unit.
- ➢ Develop providers who deliver more quality and creative programming and care.

Region Four

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 4 had a child and adolescent population ages 9-17 of 74,167. Based on prevalence estimates there are approximately 5,933 youth with SED in Region 4. DBHDD providers in Region 4 served 2,015 youth age 9-17 in SFY15 meeting 34% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 2,818 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 4 reached 71.5% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetrations rates in the child and adolescent population are estimated to be much higher if these numbers were included.

Region 4 covers 24 counties in the far Southwest corner of Georgia, bordering Southeast Alabama and North Florida. There are 9 child and adolescent providers: 3 Tier 1 providers (CCPs), 2 Tier 2 providers (CMPs) and 1 Tier 3 Specialty provider. Services other than core available to children, adolescents and their families are resiliency support clubhouse, intensive family intervention services, mobile crisis, crisis stabilization unit, forensic residential and psychiatric residential treatment facilities. In FY16, 1,239 youth received core services, 113 received CSU services, 6 received IFI services and 6 received SE services.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 4 recommended in the 2017-2018 RAC Report are:

- ❖ Increase the number of child and adolescent Behavioral Health/Addictive Diseases/Intellectual and Developmental Disabilities inpatient and crisis stabilization unit beds.
- ➢ Develop contracts with local hospitals for dedicated beds.
- ➢ Collect data on bed use.
- ➢ Create and fund local CSUs
- ➢ Collaborate with other child-serving agencies
- ❖ Expand early intervention/education/prevention to identify at risk children and adolescents for behavioral health, addictive diseases and intellectual/developmental disabilities.
- ➢ Collaborate with and utilize agencies, services, and programs already in the business of identifying at risk families and youth.

- Allocate funding and recruit dedicated staff to serve at-risk families and youth.
- Collect data on all aspects of early intervention, education and prevention.
- Redirect funds from IFI to early intervention and prevention services.
- Provide community education for families about early warning signs as well as how to access treatment.

Region Five

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 5 had a child and adolescent population ages 9-17 of 128,260. Based on prevalence estimates there are approximately 10,261 youth with SED in Region 5. DBHDD providers in Region 5 served 1,874 youth age 9-17 in SFY15 meeting 18.3% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 4,104 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 5 reached 45.7% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetrations rates in the child and adolescent population are estimated to be much higher if these numbers were included.

Region 5 is in the southeast corner of Georgia; it has a land mass of 15,128 square miles and covers 26% of the state. The region includes 34 counties. Overall population density for the region is significantly smaller than the density of the State of Georgia. There are 15 child and adolescent providers in the region: 4 Tier 1 providers (CCPs), 4 Tier 2 providers (CMPs) and 6 Tier 3 Specialty providers. Other than core services, children and adolescents in the region also have access to care management entity, resiliency supports clubhouse, mobile crisis, and crisis stabilization services as well as psychiatric residential treatment facility services. In FY16, 1,590 youth received core services, 103 received CSU services, 109 received IFI services, 2 received SE and 24 (Medicaid only) received PRTF services.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 5 recommended in the 2017-2018 RAC Report are:

- Increase overall funding at state level for DBHDD services in Georgia.
- Launch campaigns to educate legislators about public mental health services and the need for increased funding to provide these services.
- Encourage Community Service Boards to meet with local elected officials in their catchment areas to work collaboratively and creatively to use local resources to meet needs.
- Provide additional child and adolescent behavioral health services (both in schools and communities) including wrap-around services, crisis homes, expansion of 23-hour observations and/or crisis stabilization units (CSUs).
- Secure funding to add a clubhouse program.

- Increase funding to allow for expansion of Georgia Apex Program.
- Secure funding to increase the number of publicly funded CSUs.

Region 6

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 6 had a child and adolescent population ages 9-17 of 176,965. Based on prevalence estimates there are approximately 14,157 youth with SED in Region 6. DBHDD providers in Region 6 served 1,771 youth age 9-17 in SFY15 meeting 12.5% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 4,771 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 6 reached 37.1% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetrations rates in the child and adolescent population are estimated to be much higher if these numbers were included.

Region 6 ranks third in population among the six DBHDD regions and covers 9,822 square miles. Many residents live in rural areas. The region includes 31 counties. There are 22 child and adolescent providers in the region: 5 Tier 1 providers (CCPs), 13 Tier 2 providers (CMPs) and 2 Tier 3 Specialty providers. Other than core services, children and adolescents in the region also have access to care management entity, intensive family intervention services, resiliency supports clubhouse, mobile crisis, and crisis stabilization services as well as psychiatric residential treatment facility services. In FY16, 1,237 youth received core services, 174 received CSU services, 131 received IFI services and 1 received SE.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 6 recommended in the 2017-2018 RAC Report are:

- Address critical staffing shortages and the need for specialty services by recruiting providers and expanding telemedicine, mobile medicine, and crisis intervention services
- Work with Community Service Boards and other providers to identify and assess critical staff shortages
- Share this information with key stakeholders
- Work with CSBs to identify and initiate creative recruitment such as partnering with colleges and nursing schools
- Recruit credentialed providers for co-occurring disorders.
- Address shortages in rural areas through telemedicine, mobile medicine and crisis intervention services.

CHILD AND ADOLESCENT MENTAL HEALTH-PLANS TO ADDRESS UNMET NEEDS

Based on information from the analysis of available data sources, Regional Advisory Council recommendations, input from the Behavioral Health Planning and Advisory Council, and the overall strategic direction of the DBHDD, the following areas will be addressed in the 2018-2019 MHBG application.

Increase Access to Mental Health Services

As indicated previously, DBHDD does not serve all youth with SED. Given the low penetration rate of services to youth with SED served by DBHDD, DBHDD recognizes that most youth are served through the Care Management Organizations under contract with DCH, the State Medicaid Authority. The Care Management Organizations have providers in their networks who are also providers under contract or letter of agreement with DBHDD. DBHDD will work with DCH and the Georgia State University Center of Excellence for Children's Behavioral Health to collect data on youth with a behavioral health diagnosis who access services through the public mental health system.

As summarized in the data and Regional Advisory Council recommendations, there is a need to expand availability of core and specialty services to children and adolescents, particularly in rural areas of the state. There are some areas where there are limited providers. In addition, there has been the need identified to provide services closer to where children live in their homes and communities to avoid more costly and intensive out of home treatment. Since transportation has been identified as a significant issue in some parts of the state, it is important that providers plan for the delivery of non-clinic-based services such as peer services, home and community- based services and Georgia Apex. In addition to school-based mental health programing, DBHDD will continue to evaluate efforts to increase the utilization of tele-behavioral health services.

DBHDD will work with other child-serving agencies and partners to increase the number of youth with SED receiving services from the public mental health system as well as increase the number of youth receiving services in their homes and communities. The FY18-19 MHBG application includes three priority areas related to this: general access to public mental health services; home and community-based mental health services; Georgia Apex school-based mental health program; and, family and youth peer support services.

Use of Evidence-based Practices and Promising Practices

The ability to keep youth in their communities and to improve their functioning is directly related to the types of services and supports made available to them and their families. DBHDD will continue to train its workforce on evidence-based and promising practices. DBHDD will also work with other child-serving agencies to promote a system of care approach to service delivery and to encourage training across child-serving agencies on EBPs. In addition, community awareness of mental health problems leads to less stigma, less involvement with criminal justice systems and increased likelihood that youth and their families will access services.

The FY18-19 MHBG application includes training as a priority area and includes 3 strategy areas: direct care staff receiving training in evidence-based and/or promising practices; individuals trained in youth mental health first aid; and child and adolescent professionals receiving training on Culturally and Linguistically Appropriate Services.

Improve Functioning of Youth with SED

DBHDD focuses on service provision that leads to improved functioning of youth with SED. The goal is to maintain youth in their homes, schools and communities and divert them from criminal justice and higher levels of care. The use of High-Fidelity Wraparound services with Care Management Entity Services provide for a coordinated approach to planning and acquiring along with a family and youth the services and supports that are needed to maintain a youth who is challenged with SED in their communities and to improve their functioning at home, in school and in their community.

In addition, mental health resiliency support clubhouses services for children and youth (ages 6-21) with behavioral health needs provide a comprehensive and unique set of services for children and families coping with the isolation, stigma, and other challenges of mental health disorders. Clubhouse Members and their families participate in clinical sessions, social outings, and career building activities, educational support, and other structured activities designed to support their needs and help them to function better at home, in school, in the community, and throughout life.

Georgia Apex, a school-based mental health services program, was developed to enhance access to the appropriate level of care; to provide early detection of child and adolescent behavioral health needs; and to develop and sustain coordination and collaboration between Georgia's community mental health providers and the school districts in their service areas. Due to its success, the program has been expanded and will continue to expand as funds become available.

Improved functioning is a goal of service delivery to maintain the youth in their home and community. The FY20-21 MHBG application includes a priority area related to improving or maintaining functioning of youth and has an indicator to track improved functioning of youth served by the CMEs utilized in High Fidelity Wraparound services; youth served by mental health clubhouses; and, youth served through Georgia Apex.

Increase Access to Deaf Mental Health Services

It is Georgia's vision that all individuals, including individuals who are deaf, deaf-blind, or hard of hearing and utilize ASL as a preferred language, have easy access to linguistically accessible and culturally competent high-quality care that leads to a life of recovery and independence. To this end, DBHDD created the Office of Deaf Services (ODS). This office is working on the following priority areas:

- Identification of Individuals with Hearing Loss.
- Identification of Communication Preferences and Needs

- Workforce Development of Georgia Behavioral Health Interpreters (GaBHIs)
- Development of Statewide Community-Based Accessible Services
- Deaf Services Provider Training Series
- Promotion of Public Information Awareness and Community Outreach

DBHDD has developed a priority area and indicator related to this population for this MHBG application. The goal is to increase access to community-based mental health services for adults with SMI and children with SED who require American Sign Language to access services.

Increase Access to Coordinated Specialty Care

Georgia has used the 10 percent set-aside funds to support its LIGHT-ETP (Listening, Inspiring, Guiding Healthy Transitions-Early Treatment Program) initiative for young people with first- episode psychosis. This initiative provides Coordinated Specialty Care (CSC) to young people between the ages of 16-30 who have been experiencing symptoms of a psychotic disorder for 24 months or less. The evidence-based practices provided by our CSC teams include medication management geared toward young people with first-episode psychosis; CBT-based psychotherapy; case management and coordination with primary care; supported education and supported employment based on the Individualized Placement and Support model; family education and support; and peer support.

Since 2014, DBHDD has been planning for development of and implementation of the CSC model. To support development, DBHDD formed a stakeholder group and hired a part-time project coordinator. Based on the stakeholder recommendations, DBHDD provided initial training on the model as well as a community awareness campaign. Also, initially DBHDD procured three providers to implement the service in 14 counties in 3 DBHDD regions. In SFY17, DBHDD secured two additional providers and expanded to an additional 20 counties in 2 more DBHDD regions. In SFY18, DBHDD secured one more provider and has expanded services to 7 additional counties. All but one DBHDD region have implemented CSC. To support the current sites and to plan for sustainability and replication, DBHDD has converted the part-time project coordinator position to a full-time position. The Project Coordinator has expertise in the provision of and training of CSC and works with each provider site to support their implementation. The Coordinator will also work internally and externally on development of financing plans for further sustainability of the CSC model.

The FY18 MHBG application includes a goals and indicator related to CSC services. DBHDD will monitor the number of individuals receiving CSC with a focus on increasing the number served as new tams are added for the provision of CSC.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Community Mental Health Services

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Access to Mental Health Services

Objective:

Increase access to mental health services.

Strategies to attain the objective:

DBHDD will work with DBHDD providers and other state agencies to support access to public mental health system services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth accessing services through the public mental health system.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same level of youth accessing services as in SFY19.

Second-year target/outcome measurement: Increase SFY20 number by 100 youth.

Data Source:

Medicaid and state funded claims and encounters; Georgia Collaborative Administrative Service Organization; Center of Excellence for Children's Behavioral Health, Georgia State University.

Description of Data:

Data includes number of youth accessing services through DBHDD core and specialty services.

Data issues/caveats that affect outcome measures::

Data will be compiled from different sources.

Indicator #: 2

Indicator: Percentage of youth receiving at least one home- and community-based mental health service.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same level of youth accessing services as in SFY19.

Second-year target/outcome measurement: Increase by 1% over data reported in SYF20.

Data Source:

Medicaid and state funded claims and encounters; Georgia Collaborative Administrative Service Organization.

Description of Data:

Data includes number of youth accessing services through DBHDD providers, such as Community Support Individual and Intensive Family Intervention.

Data issues/caveats that affect outcome measures::

School-based mental health services will be reported separately.

Indicator #: 3

Indicator: *Number of youth accessing services through the Georgia Apex school-based mental health program.*

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Increase by 250 youth over baseline data.

Second-year target/outcome measurement: Increase baseline number by 250 youth over data reported in SYF20.

Data Source:

Data reported to Center of Excellence for Children's Behavioral Health, Georgia State University.

Description of Data:

Data includes number of youth accessing services through DBHDD Tier 1 and Tier 2 providers embedded in schools.

Data issues/caveats that affect outcome measures::

The data relies on providers self-reporting.

Indicator #: 4

Indicator: Number of youth and families receiving peer services.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same level of youth and families receiving peer services as in SFY19.

Second-year target/outcome measurement: Increase by 1% over data reported in SFY19.

Data Source:

Medicaid claims and encounters; Georgia Collaborative Administrative Service Organization; Georgia Parent Support Network program data

Description of Data:

Data includes number of youth and parents receiving support through the DBHDD provider network from a certified parent or youth peer.

Data issues/caveats that affect outcome measures::

This will be a new measure tracked through the Georgia Collaborative Administrative Service Organization.

Priority #: 2

Priority Area: Training

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Train DBHDD providers on evidence-based and/or promising practices

Objective:

DBHDD providers are trained on and implementing evidence-based practices and/or promising practices (EBPs/PPs)

Strategies to attain the objective:

DBHDD will train enrolled providers in evidence-based and/or promising practices. Use of EBPs/PPs are indicated in the DBHDD Provider Manual.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of direct care staff receiving training in evidence-based and/or promising practices.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Increase by 5% over data reported in SFY19.

Second-year target/outcome measurement: Increase by 2% over data reported in SFY20.

Data Source:

DBHDD Office of Learning and vendor reports.

Description of Data:

Data collected from registration and attendance lists.

Data issues/caveats that affect outcome measures::

Data will be compiled from different sources.

Indicator #: 2

Indicator: Number of individuals trained in youth mental health first aid.

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Increase baseline number by 50 child serving professionals over SFY19 data.

Second-year target/outcome measurement: Increase number by 50 child serving professionals over SFY20 data.

Data Source:

YMHFA vendor reports.

Description of Data:

Data collected from attendance lists. YMHFA is primarily designed for adults (e.g., family members, caregivers, school staff, etc.) who regularly engage with young people 12-25. However, YMHFA is also appropriate as a peer support program for older adolescents.

Data issues/caveats that affect outcome measures::

The DBHDD Office of Children, Young Adults & Families contracts for YMHFA to build capacity for trained individuals in the state.

Indicator #: 3

Indicator: Number of CYF professionals participating in a Culturally and Linguistically Appropriate Services (CLAS) training.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Increase number by 35 child-serving professionals over SFY19.

Second-year target/outcome measurement: Increase number by 75 child-serving professionals over SFY20.

Data Source:

DBHDD Office of Learning and vendor reports.

Description of Data:

Data collected from registration lists.

Data issues/caveats that affect outcome measures::

This will be a new measure tracked by DBHDD.

Priority #: 3

Priority Area: Improved Functioning

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Children and youth receiving services will improve functioning.

Objective:

To increase functioning of children and adolescents who receive community mental health services.

Strategies to attain the objective:

Providers will work with youth and their families with the goal of improving youth functioning in homes, schools, and communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of youth receiving High Fidelity Wraparound services from Care Management Entity (CME) who increase functioning.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Increase by 1% over data reported in SFY19

Second-year target/outcome measurement: Increase by 1% over data reported in SFY20.

Data Source:

Center of Excellence for Children's Behavioral Health, Georgia State University; CME annual evaluation.

Description of Data:

CMEs will measure functioning using the Child and Adolescent Needs and Strengths (CANS) tool.

Data issues/caveats that affect outcome measures::

DBHDD is evaluating the utility of switching to a new electronic health record system.

Indicator #: 2

Indicator: Percentage of youth mental health clubhouse members who increase functioning.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same percentage of youth mental health clubhouse members who increase functioning as in SFY19.

Second-year target/outcome measurement: Increase by 1% over data reported in SFY20.

Data Source:

Center of Excellence for Children's Behavioral Health, Georgia State University; mental health clubhouse annual evaluation.

Description of Data:

DBHDD mental health clubhouse providers will measure functioning using the Child and Adolescent Needs and Strengths (CANS) tool.

Data issues/caveats that affect outcome measures::

This will be a new measure tracked by DBHDD.

Indicator #: 3

Indicator: Percentage of school-based mental health program members who increase functioning.

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transitional year. Our year 1 goal is to maintain at least the same percentage of school-based mental health program members who increase functioning as in SFY19.

Second-year target/outcome measurement: Increase by 1% over data reported in SFY20

Data Source:

Center of Excellence for Children's Behavioral Health, Georgia State University; Georgia Apex Program annual evaluation.

Description of Data:

DBHDD Apex providers will measure functioning using the Child and Adolescent Needs and Strengths (CANS) tool.

Data issues/caveats that affect outcome measures::

This will be a new measure tracked by DBHDD.

Priority #: 4

Priority Area: Access to Coordinated Specialty Care

Priority Type:

Population(s): ESMI

Goal of the priority area:

Youth and young adults ages 16-30 with First-Episode Psychosis will receive Coordinated Specialty Care (CSC) services.

Objective:

To continue to increase the number of youth and young adults receiving CSC services.

Strategies to attain the objective:

DBHDD will continue to provide technical assistance to CSC providers to ensure that their community outreach and education efforts result in referrals of eligible youth and young adults into CSC programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and young adults with FEP receiving CSC services.

Baseline Measurement: SFY16 will serve as the baseline year. DBHDD expected that providers in the three pilot sites would enroll a minimum of 60 individuals during the baseline year. The three pilot sites enrolled 87 individuals in SFY16. DBHDD's goal for SFY17 was a 10% increase in the number of individuals served in SFY16. In SFY17, 105 individuals were served in CSC programs. DBHDD's goal for SFY18 was a 5% increase in the number of individuals served in SFY17. In

SFY18, 196 individuals were served in CSC programs. DBHDD's goal for SFY19 was a 5% increase in the number of individuals served in SFY18. In SFY19, 219 individuals were served in CSC programs.

First-year target/outcome measurement: DBHDD will increase the number of individuals with first-episode psychosis receiving CSC services by 5% over the number served in SFY2019.

Second-year target/outcome measurement: DBHDD will increase the number of individuals with first-episode psychosis receiving CSC services by 5% over the number served in SFY2020.

Data Source:

Monthly reports completed by providers.

Description of Data:

Number of individuals with FEP enrolled and retained in CSC services.

Data issues/caveats that affect outcome measures::

None.

Priority #: 5

Priority Area: Deaf Mental Health Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Access to community-based non-crisis mental health therapy (individual, family and group)

Objective:

Increase access to non-crisis therapy for adults with SMI and children with SED who require American Sign Language (ASL) or visual gestural language to access services and are state (uninsured) or Medicaid (SSI) funded.

Strategies to attain the objective:

DBHDD will work with DBHDD Designated Provider(s) and other state agencies to support access to public mental health

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals who: are identified as deaf; receive state or Medicaid funds; and, are authorized for community-based non-crisis mental health therapy that receive a Communication Assessment Report.

Baseline Measurement: Number of individuals who: are identified as deaf; receive state or Medicaid funds; and, are authorized for community-based non-crisis mental health therapy that receive a Communication Assessment Report in SFY19.

First-year target/outcome measurement: 5% increase over data reported in SFY19.

Second-year target/outcome measurement: 7% increase over data reported in SFY20.

Data Source:

Designated Provider Data Reports, Administrative Services Organization (ASO) and Deaf Services Data Management System (DSMS)

Description of Data:

DP Data Reports – Monthly service reports of individuals who are being served through the ASL program.

ASO – Monthly database report of individuals identified as deaf (adults and children), receive state (uninsured) or Medicaid (non-MCO) funds, and are authorized for community-based non-crisis mental health therapy (individual, group, and family) services.

DSMS – Monthly database report of individuals identified as deaf (adults and children), receive state (uninsured) or Medicaid (non-MCO) funds, and are authorized for community-based non-crisis mental health therapy (individual, group, and family) services that have a Communication Assessment Report.

The indicator percentage will be based on the number of individuals from the DSMS report that are present on the ASO report as compared between the Designated Provider Reports of those receiving services in the first and second years.

Data issues/caveats that affect outcome measures::

None

Priority #: 6

Priority Area: Permanent Supported Housing

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase access to permanent supported housing for adults enrolled in AMH services.

Objective:

To support access to permanent supported housing for eligible individuals.

Strategies to attain the objective:

DBHDD will increase access to HUD Section 811 program, and DCA Housing Choice Vouchers for eligible adults with SMI.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults with SMI receiving State assisted permanent supported housing.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same number of adults with SMI receiving State assisted permanent supported housing. as in SFY19.

Second-year target/outcome measurement: Increase number served by 3% over the total served in SFY20

Data Source:

Office of Adult Mental Health data base, Department of Community Affairs data base/Statewide Information System

Description of Data:

Compiled monthly reports of individuals housed via the GHV, HCV OR 811 rental assistance programs.

Data issues/caveats that affect outcome measures::

None

Priority #: 7

Priority Area: Provider training

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provision of diverse training to community adult mental health providers

Objective:

Increase access to training focused on supporting the behavioral health of diverse populations of adults with SMI

Strategies to attain the objective:

DBHDD will provide high quality training to community adult mental health providers throughout the state that will increase skills in supporting the behavioral health needs of diverse populations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Provision of training on each of the following topics: Trauma-informed Care; Recovery *focused service delivery; Cultural and linguistic competency; behavioral health needs of* veterans; behavioral health needs of those with criminal history; Mental Health First Aid; and, behavioral health needs of LGBT individuals

Baseline Measurement: Initial data collected during SFY2019

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor training expenditures and work to mitigate any potential negative impact on training delivery during this transition year. Our year 1 goal is to maintain at least the same number of providers who are trained in the above topic areas .as in SFY19.

Second-year target/outcome measurement: Increase number of providers trained by 5% above SFY20 totals.

Data Source:

DBHDD Office of Adult Mental Health data.

Description of Data:

Training plan reflecting dates and topics.

Data issues/caveats that affect outcome measures::

None

Priority #: 8

Priority Area: Supported Employment

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase access to competitive employment for adults enrolled in AMH services.

Objective:

Increase number of adults with SMI to obtain and maintain competitive employment.

Strategies to attain the objective:

DBHDD contracts for the provision of Supported Employment services statewide. Collect data on number of individuals working part or full time in competitive employment settings for adults with SMI receiving State funded Supported Employment services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of adults with SMI who are competitively employed part-time or full-time while enrolled in adult mental health Supported Employment services.

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor

services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same percentage of adults with SMI who are competitively employed part-time or full-time while enrolled in adult mental health Supported Employment services. as in SFY19.

Second-year target/outcome measurement: Increase percentage of SE enrolled individuals who are competitively employed by 5% above SFY20 number.

Data Source:

DBHDD Office of Adult Mental Health data.

Description of Data:

Compiled monthly reports of individuals enrolled in SE, and % of individuals competitively employed.

Data issues/caveats that affect outcome measures::

None

Priority #: 9

Priority Area: Access to Services-Older Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Improve providers ability to support the behavioral health needs of older adults

Objective:

Increase access to community mental health services by adults with SMI aged 65 and older.

Strategies to attain the objective:

Offer training opportunities that will enhance providers ability to deliver behavioral health services to adults age 65+

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of adults with SMI age 65+ that receive community mental health services.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same percentage of adults with SMI age 65+ that receive community mental health services as in SFY19.

Second-year target/outcome measurement: Increase by 2% the number of 65+ individuals who received community based adult mental health services in SFY20

Data Source:

DBHDD Office of Adult Mental Health data.

Description of Data:

Authorizations submitted for AMH services for persons 65+

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: Provision of cross training for behavioral health providers on awareness and issues related to the delivery of mental health services to older adults with SMI.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor training expenditures and work to mitigate any potential negative impact on training delivery during this transition year. Our year 1 goal is to maintain at least the same number of providers who receive cross training for behavioral health providers on awareness and issues related to the delivery of mental health services to older adults with SMI as in SFY19.

Second-year target/outcome measurement: Increase number of providers trained by 10% over SFY20.

Data Source:

DBHDD Office of Adult Mental Health data.

Description of Data:

Training plan reflecting dates and topics.

Data issues/caveats that affect outcome measures::

None

Priority #: 10

Priority Area: Access to Services- Criminal Justice

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Access to behavioral health services for returning citizens/criminal justice involved individuals with behavioral health needs.

Objective:

To improve access to community behavioral health service for persons with behavioral health needs transitioning from a criminal justice facility back into the community.

Strategies to attain the objective:

Increase efforts to support access to behavioral health services for criminal justice involved individuals with behavioral health needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults with SMI referred from jail, prison, and Day Reporting Centers to community mental health services.

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same number of adults with SMI referred from jail, prison, and Day Reporting Centers to community mental health services as in SFY19.

Second-year target/outcome measurement: Increase by 3% the number of adults with SMI referred from jail, prison or a Day Reporting Center into community mental health services above the SFY20 total.

Data Source:

Office of Adult Mental Health data, DBHDD Administrative Services Organization.

Description of Data:

Authorizations submitted for AMH services for persons from jail, prison, and Day Reporting Center

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: Number of adults with SMI receiving forensic peer support.

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same number of adults with SMI receiving forensic peer support as in SFY19.

Second-year target/outcome measurement: Increase by 5% over SFY20 data.

Data Source:

Office of Adult Mental Health data,

Description of Data:

Compiled monthly report data from forensic peer specialists

Data issues/caveats that affect outcome measures::

None

Priority #: 11

Priority Area: Access to Community Mental Health Services for Homeless Individuals with SMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase number of homeless individuals with SMI accessing community adult mental health services.

Objective:

To improve awareness of and access to community behavioral health services for homeless individuals with SMI

Strategies to attain the objective:

To build upon current use of PATH services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults with SMI receiving PATH services for homeless individuals with behavioral health needs

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Due to significant budget cuts (required by the state legislature) in areas that frequently coordinate with delivery of PATH services, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same number of adults with SMI receiving PATH services for homeless individuals with behavioral health needs as in SFY19.

Second-year target/outcome measurement: Increase number of persons served by PATH by 3% above the SFY20 total.

Data Source:

Statewide HMIS System; ASO data

Description of Data:

Comparison of authorizations submitted for AMH services, past – current fiscal years, monthly report census data for PATH

Data issues/caveats that affect outcome measures::

None

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$0	$0	$30,661,016	$1,764,562	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$2,223,070	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$2,828,942	$0	$103,847,917	$0	$820,122
7. Other 24 Hour Care		$0	$0	$0	$304,789,943	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$18,671,218	$34,365,827	$3,089,183	$538,394,533	$0	$1,547,321
9. Administration (Excluding Program and Provider Level)***		$1,099,524	$0	$0	$32,546,688	$0	$0
10. Total	**$0**	**$21,993,812**	**$37,194,769**	**$33,750,199**	**$981,343,643**	**$0**	**$2,367,443**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development

MHBG Planning Period Start Date: 07/01/2019 MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant	FFY 2021 Block Grant
1. Information Systems	$0	$0
2. Infrastructure Support	$1,253,036	$722,496
3. Partnerships, community outreach, and needs assessment	$0	$0
4. Planning Council Activities (MHBG required, SABG optional)	$127,272	$127,272
5. Quality Assurance and Improvement	$0	$0
6. Research and Evaluation	$0	$0
7. Training and Education	$818,740	$739,884
8. Total	**$2,199,048**	**$1,589,652**

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Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

   Georgia has implemented a service called Peer Support Whole Health and Wellness which allows Certified Peer Specialists who are trained in whole health principles to support individuals in achieving health goals. These CPSs are trained in the Whole Health Action Management curriculum. The state continues to grow this workforce offering this additional certification opportunity to at least 60 CPSs/year. The state is also implementing a new modality of delivering this service, complementing the existing 1:1 service delivery model with a new group model (effective Fall 2017).

   Additionally, several services in the benefit which DBHDD provides allow health access and promotion. Nursing services allow basic health screening including BMI measurement, weight monitoring, blood pressure screening and vitals monitoring. Case management services promote facilitating access to health interventions and coordination with those healthcare practitioners.

   The DBHDD has also worked with the state's Medicaid authority to clarify the billing allowance for same-day service provision between the DBHDD provider network and Federally Qualified Health Centers (FQHCs) (effective January 2019) and to release guidance to providers on how to access smoking cessation supports through a Medicaid-enrolled primary care physician.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

   Since the early 2000s, the DBHDD has promoted MH and SUD integration at the person-served point of access. The basic core services provided by our agency share integrated policy, authorization procedures, and payment strategies. For instance, our Individual Counseling definition is for either individuals with a mental illness, substance use disorder, or both. When an authorization is reviewed, it considers one or both of the conditions (without mandate to address one condition or the other).Rates of reimbursement are also identical..

   The state has also recently introduced Parent and Youth Peer Support to the state benefit plan. Certified Peer Specialist- Parents (CPS-Ps) and Certified Peer Specialists-Youth (CPS-Ys) receive a co-occurring-competent curriculum and training to be prepared to serve the needs of all individuals regardless of whether there is a mental health condition, substance use disorder, or both.

   In October 2017, DBHDD and the State Medicaid authority added Behavioral Health Clinical Consultation to the Medicaid State Plan for Georgia. This service enables a physician/extender with the enrolled DBHDD agency provides to provide or receive

specialty expertise opinion and/or treatment advice to/from another treating physician/extender regarding an individual who is enrolled receiving DBHDD services/supports. The service promotes:

- Sound, collaborative clinical/medical opinions from other experts related to the behavioral health condition; and/or
- Assistance for the behavioral health/medical provider with diagnosing; and/or
- Consultation about alternatives to medication, medication combined with psychosocial treatments and potential results of medication usage; and/or
- Identification and planning for additional services; and/or
- Coordination or informed revision to a treatment and/or recovery plan; and/or
- Understanding of the complexities of co-occurring medical conditions on the individual's behavioral health recovery plan (e.g. kidney failure, diabetes, high blood pressure, etc.); and/or
- Partnered review of the individual's progress for the purposes of collaborative treatment outcomes.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? (●) Yes ( ) No

   b) and Medicaid? (●) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

   DBHDD as SSA/SMHA

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ( ) Yes (●) No

6. Do the M/SUD providers screen and refer for:

   a) Prevention and wellness education (●) Yes ( ) No

   b) Health risks such as

   ii) heart disease (●) Yes ( ) No

   iii) hypertension (●) Yes ( ) No

   iv) high cholesterol (●) Yes ( ) No

   v) diabetes (●) Yes ( ) No

   c) Recovery supports (●) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ( ) Yes (●) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? (●) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

   There has been turnover in leadership at the Office of the Insurance Commissioner.
   Issues with capacity within state insurance office to complete parity review and follow up

10. Does the state have any activities related to this section that you would like to highlight?

    The state has a collaborative review committee which includes the Office of the Insurance Commissioner, SMHA, and SMA to consider parity for Medicaid Managed Care and private insurance. That team has presented together at the SMHA's System of Care conference which includes payers, families, youth and providers.

    Please indicate areas of technical assistance needed related to this section

    None at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(●) Yes ( ) No
b) Ethnicity	(●) Yes ( ) No
c) Gender	(●) Yes ( ) No
d) Sexual orientation	( ) Yes (●) No
e) Gender identity	( ) Yes (●) No
f) Age	(●) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ( ) Yes (●) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ( ) Yes (●) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ( ) Yes (●) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ( ) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (●) No

7. Does the state have any activities related to this section that you would like to highlight?

Although DBHDD does not have a formalized workforce training plan, DBHDD annually offers cultural and linguistic competence training at its Annual Provider Behavioral Health Symposium and has included an overview of the CLAS Standards during these sessions.

The annual Georgia School of Addiction Studies (GSAS) offers a unique opportunity for professional development, information exchange, and networking. It is designed to address the need for knowledge and skill development through advanced training. The purpose of the GSAS is to: 1) foster and maintain the integrity of substance abuse related services by assisting in providing continuing training and education programs for more than 500 human service providers each year whose duties include prevention, intervention, treatment, law enforcement, child welfare, victim's services, law enforcement, court system, education, and rehabilitation or related social services; 2) to promote a broader understanding of, response to, and acceptance of, the process of addiction and its impact in areas of health, family, community, crime and the workplace; and 3) to encourage the exchange of professional knowledge through educational conferences and other programs of continuing education.

Six DBHDD Office of Addictive Disease staff and two members of the Office of Behavioral Health Prevention staff serve on the Georgia School of Addiction Studies Board and help plan the conference program agenda. The five day annual conference includes a treatment track on Cultural Competency. The 13th Annual Conference, held August 26-29, 2019 includes the following training workshops: Exploring Innovative Evaluation Approaches to Better Understand the Changing Faces of Rural Communities; Implementing Cultural Competence in a Trauma Informed Setting for Emerging Adults with Co-Occurring Disorders; Understanding Military Re-Entry Needs Back into the Community; Cultural Competency for the Prevention Professional– Part 1 &2; Why are Bisexual and Transgender Populations Overlooked Within the LGBTQ Spectrum?; Addiction In The Church: Bridging the Gap Between Christianity and Recovery; and Retaining and Treating Women with Substance Use Disorders: Being Gender Responsive and Culturally Sensitive.

A past workgroup within DBHDD developed a draft CLC Action Plan outlining steps to be taken by the Department to address items 2-6, however, that plan has not been approved as of this time. In August 2018 DBHDD created the new Office of Federal Grant Programs and Cultural and Linguistic Competency, inorder to prioritize CLC goals and objectives. The Director of this Office will lead the Department in revising the existing CLC Action Plan and implementing policy and practice changes for the state in this area.

Please indicate areas of technical assistance needed related to this section

We are open to any technical assistance related to addressing items 2-6.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

   a) ☑ Leadership support, including investment of human and financial resources.

   b) ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   c) ☑ Use of financial and non-financial incentives for providers or consumers.

   d) ☐ Provider involvement in planning value-based purchasing.

   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

   f) ☐ Quality measures focus on consumer outcomes rather than care processes.

   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

   The state has set forth a set of performance expectations for its provider network which include measures for access, provider capacity, consumer choice, provider efficiency, and adherence to service policy, to name a few. These measures are monitored and reported annually. DBHDD is in the developmental stages of creating dashboard report cards to promote use of the findings for quality improvement.

   As related to evidence-based fidelity, the DBHDD continues to utilize the Dartmouth models of fidelity for its Assertive Community Treatment program and Supported Employment service delivery.

   Please indicate areas of technical assistance needed related to this section.

   None

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2. C. We are in the testing phase of this with a small pilot program related to assisting individuals that are frequent users of the crisis system.

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   Georgia has used the 10 percent set-aside funds to support its LIGHT-ETP (Listening, Inspiring, Guiding Healthy Transitions -Early Treatment Program) initiative for young people with first-episode psychosis. This initiative provides Coordinated Specialty Care (CSC) to young people between the ages of 16-30 who have been experiencing symptoms of a psychotic disorder for 24 months or less. The evidence-based practices provided by our Coordinated Specialty Care teams include medication management geared toward young people with first-episode psychosis; CBT-based psychotherapy; case management and coordination with primary care; supported education and supported employment based on the Individualized Placement and Support model; family education and support; and peer support.

   Currently Georgia funds eight (8) CSC teams operated through five (5) Community Service Boards, the publicly-funded system of services for mental health, substance abuse, and intellectual disability; and one (1) hospital.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Our providers offering Coordinated Specialty Care programs conduct extensive community outreach and education to ensure that community stakeholders including area hospitals, first responders, crisis stabilization centers, behavioral health providers, primary care providers, child-serving agencies, colleges, high schools, technical schools, jail diversion programs, homeless shelters, advocacy organizations, and other entities are aware of the signs and symptoms of early psychosis, are familiar with Coordinated Specialty Care, and know how to refer individuals to CSC programs. To supplement the providers' outreach efforts, DBHDD developed a public awareness campaign on first-episode psychosis and CSC targeted to the communities where the CSC programs are located. The campaign included print and radio ads, billboards, and social media posts. In addition, DBHDD has promoted its first-episode initiative and the importance of comprehensive, individualized treatment for young people in the early stages of severe mental illness through presentations at statewide behavioral health committee meetings, conferences, and training events.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? (●) Yes ( ) No

5. Does the state collect data specifically related to ESMI? (●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

In 2016 and 2017, the state continued to fund Coordinated Specialty Care programs established in April 2015 at Advantage Behavioral Health Systems, covering 10 counties in the Athens, GA area; and at View Point Health in Atlanta, which expanded to operate two teams serving a five-county urban/suburban area. DBHDD also began funding three additional CSC programs: Albany Aspire, covering rural communities in and around the Albany, GA region; River Edge Behavioral Health, in Macon; and McIntosh Trail Community Service Board, in the south Metro Atlanta area. The target population, initially individuals between the ages of 16 -25 who have been experiencing symptoms of psychosis for no longer than 18 months, was broadened to include individuals between 16-30 who have been experiencing symptoms for no longer than 24 months. The teams have similar staffing patterns (Team Lead/Therapist, Case Manager, Supported Education/Employment Specialist, Peer Support Specialist, Family Peer Specialist, Nurse, Prescriber) and have maximum caseloads of 30 individuals at a point in time.

In 2018, DBHDD funded another Coordinated Specialty Care program at New Horizons Behavioral Health in Columbus, GA. This team began serving individuals in October 2018. In June of 2019, the eighth CSC team began operating at Grady Health System in Atlanta, GA.

DBHDD has been providing ongoing training and technical assistance to all CSC programs and holds quarterly Learning Collaborative meetings for all CSC program staff and DBHDD field office representatives. The Learning Collaboratives are opportunities for CSC programs to exchange knowledge and resources and to address implementation and sustainability challenges. As the state's newer CSC programs began start-up activities, the initial teams were instrumental in providing guidance and sharing best practices.

CSC teams have presented on their work at national and statewide conferences and training events, including the annual Behavioral Health Symposium and System of Care Academy. Two of Georgia's teams are participating in the SAMHSA/NIMH National Evaluation of the Mental Health Block Grant Ten Percent Early Intervention Study examining the implementation of CSC programs around the country.

DBHDD continues to partner with Georgia State University's Center of Excellence on data collection, analysis, and fidelity and outcomes monitoring for the CSC programs and participates in national technical assistance opportunities focused on program improvement and sustainability.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

DBHDD plans to (1) continue supporting our eight (8) CSC programs; (2) provide ongoing training and technical assistance to all CSC programs; (3) continue holding quarterly Learning Collaborative meetings; (4) continue providing information and training on first-episode psychosis and best practices to our provider network and community partners through existing forums; and (5) collaborate with Georgia State University's Center of Excellence on fidelity and outcomes reviews, surveys of program participants' and families' experiences in CSC programs; and satisfaction with services.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

DBHDD and Georgia State University's Center of Excellence (COE) have developed fidelity and outcomes monitoring reports for the CSC programs. The providers complete these reports on a monthly basis, and the COE compiles this data into quarterly reports which are reviewed with providers individually and during the quarterly Learning Collaborative meetings.

Information obtained from providers includes baseline data on program participants at enrollment in the CSC program (age, gender, race/ethnicity, insurance, diagnosis, education, employment, family involvement, living situation, hospitalizations, suicidality, substance use detox/rehab admissions, legal system involvement) as well as the following data elements:

- Number of referrals received
- Referral sources
- Number of eligible and ineligible individuals referred, and reasons for ineligibility
- Length of time between referral and enrollment of eligible individuals

- Length of time between enrollment and appointment with team prescriber
- Program census
- Discharges, reasons for discharge, and services to which discharged participants were linked
- Service utilization rates
- Outcomes, including symptom reduction, hospitalizations, suicide attempts, legal system involvement, work/school participation
- Team activities, including weekly team meetings held and participating staff
- Number and type of community outreach/education activities and events
- Number and type of trainings attended by staff
- Staff vacancies
- After-hours contacts and contacts in the community

Review and analysis of this data supports continuous quality improvement processes at the provider and state level, informs decision-making, and helps to identify training and technical assistance needs.

10. Please list the diagnostic categories identified for your state's ESMI programs.

The target population for the CSC initiative is young adults between the ages of 16 and 30 who have been experiencing psychotic symptoms for 24 months or less and who meet criteria for the following psychiatric disorders:

- Schizophrenia
- Schizophreniform Disorder
- Schizoaffective Disorder
- Bipolar Disorder I with Psychotic Features
- Major Depressive Disorder with Psychotic Features
- Delusional Disorder
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Individuals who meet the above criteria and who have a co-occurring substance use disorder may be served by CSC teams. Individuals with moderate to profound intellectual/ developmental disabilities, medical conditions suspected to be the cause of the psychotic symptoms, and substance-induced psychotic symptoms are ineligible for CSC services.

The inclusion in Georgia's CSC programs of peer support specialists for young people, and parent peer support specialists, is viewed by CSC teams as a significant factor in the engagement and retention of program participants and key to instilling a sense of hope in young people and their families at this critical juncture in their lives.

Please indicate areas of technical assistance needed related to this section.

At this time, we do not anticipate any technical assistance needs in this area.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person?s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person?s needs and desires.

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

It is the policy of DBHDD to ensure compliance with applicable state and federal laws and regulations regarding confidentiality and privacy of a person's health care information, including information about mental health, developmental disabilities, or substance use disorders.

DBHDD contracted providers and or staff encourage individuals to include their representatives/caregivers, natural and/or paid supports to participate in discussions regarding health care decisions and to enhance communication. It is expected that DBHDD contracted providers and or staff will invite persons to participate in these discussions.

4. Describe the person-centered planning process in your state.

Community services are provided through contracts with private, for-profit, non-profit, and quasi-public agencies, under contract with DBHDD. Individual choice is a value that is embraced throughout the system, and is fostered through the development of different kinds of provider agencies, including consumer operated agencies. These organizations vary in scope of services provided including those services commonly utilized by anyone with a mental illness and those services that address more individualized needs.

An individual's own recovery goals are considered when developing the person centered plan of care and assisting with the linkage to community based services after transition into the community. Once a community service provider is identified, and a release of information is obtained from the individual, the provider is strongly encouraged to actively engage in the transitioning and discharge planning process. The hospital is recovery focused and utilizes the "Individualized Recovery Plan" to guide an individual's treatment and recovery.

For individuals who have taken longer to stabilize (more than 45 days) or who have been readmitted within 30 days of discharge or 3 times in 12 months receive an additional level of transition planning for the individual's successful transition into the community.

DBHDD embraces Georgia's Recovery Definition and Guiding Principles & Values, which best describe the state of Georgia's person-centered planning process.

Georgia's Recovery Definition
• Recovery is a deeply personal, unique, and self-determined journey through which an individual strives to reach his/her full potential. Persons in recovery improve their health and wellness by taking responsibility in pursuing a fulfilling and contributing life while embracing the difficulties one has faced.
• Recovery is not a gift from any system. Recovery is nurtured by relationships and environments that provide hope, empowerment, choices and opportunities.
• Recovery belongs to the person. It is a right, and it is the responsibility of us all.

Georgia's Recovery Guiding Principles & Values

Recovery...

- Emerges from hope
- Is person-driven
- Strengths based
- Age Independent
- Recognizes the wisdom of "lived experiences"
- Occurs via many pathways
- Is holistic
- Is supported by peers, allies, advocates and families
- Is nurtured through relationships and social networks
- Is culturally based and influenced
- Is anchored in wellness- addressing a person's emotional health, environmental well-being, financial satisfaction, intellectual creativity, occupational pursuits, physical activities, social engagement and spiritual health
- Addresses trauma
- Supports self- responsibility
- Empowers communities
- Is based on respect

Please indicate areas of technical assistance needed related to this section.

None at this time.

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DBHDD has engaged the services of trainers and consultants to provide a series of trainings on recovery-oriented service delivery and recovery-focused treatment. This has been instrumental in promoting person-centered, recovery-oriented services throughout our adult behavioral health system.

In February 2019, the National Center on Advancing Person-Centered Practices and Systems (NCAPPS) received 33 applications for technical assistance, and 15 states were selected for the first cohort. Technical assistance recipients work with national subject matter experts toward individualized goals focused on systems change to ensure the person is at the center of service organization and delivery. The Georgia Department of Human Services, Division of Aging Services (DAS) was selected. As a result of ongoing collaboration with DAS, DBHDD was invited to participate as a collaborative partner in the NCAPPS technical assistance process. The project is focused on developing cross-system definitions, language, and policies that will promote enhanced person-centered planning and better coordination of care for mutual clients.

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

   1. Various staff at the Department and Regional level have responsibility for Program Integrity activities that are currently done. Additionally, DBHDD has also developed a list of policies and procedures that are general in nature and applicable to all departments as it relates to managing and monitoring programs that receive Federal award dollars. Additionally, this policy also includes a list of program-specific policies and procedures maintained by the Agency. These policies and procedures have been developed to help ensure that management's directives are carried out as they relate to each applicable OMB compliance requirements. These policies and procedures highlight the control activities and/or internal controls present and describe the proper management of sub-recipient activity.

   2. For those services under contract that are Evidence-based practices, DBHDD staff have implemented fidelity monitoring activities that involve technical assistance and training. Some examples are ACT, Supported Employment and Care Management Entity Services. In addition, through review of monthly programmatic and expenditure reports, staff monitor compliance with contract deliverables.

   3. All providers under contract or letter of agreement with DBHDD must adhere to the Policy, Payment by Individuals for Community Behavioral Health Services, 01-107. This policy applies to organizations under contract, letter of agreement,

memorandum of understanding or service agreement with DBHDD to provide community based Mental Health and Addictive Diseases services. This policy governs services provided to individuals who meet DBHDD established eligibility criteria requirements for mental health and/or addictive diseases services. This policy indicates that DBHDD funds are payment of last resort.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state?s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   Georgia does not have any federally recognized tribal governments or tribal lands within the state's borders.

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

   N/A

   Please indicate areas of technical assistance needed related to this section.

   N/A

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Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

   Georgia's adult mental health state service system includes an array of Core, Specialty, Crisis, and Inpatient services. Adult Mental Health has invested considerable resources to ensure availability of a comprehensive array of intensive, out-of-hospital services including the development of intensive treatment residences, mobile crisis response teams, community based crisis stabilization units, assertive community treatment and community support services, intensive case management as well as psychosocial rehabilitation, peer wellness centers and a host of other community based programming all with the goal of supporting a meaningful life in the community for all of Georgia's citizens. Below are services for adult mental health:

   Access and Referral Service

   • Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance needs mental health crisis services. The Georgia Crisis and Access Line is a 24 hour/7 day a week resource for Georgians who need either routine, crisis, or inpatient behavioral health services. The system, which includes mobile crisis services in several counties, provides fast and accurate connections with on-the-spot appointment scheduling for services.

   Core Services

   • Diagnostic Assessment and Individualized Recovery/Resiliency Planning

   Individuals have the opportunity to meet with clinicians, physicians, nurses, peer specialists and care managers to receive comprehensive assessment, a recovery plan built to specification and individual driven and linkage to other community-based services such as housing, employment, whole health planning and support programs. A diagnostic assessment is provided by a physician or advanced practice nurse or physician's assistant trained in psychiatry and includes a bio-psychosocial history, mental status exam, evaluation and assessment of physiological phenomena, psychiatric evaluation, screen for withdrawal if indicated, assessment of appropriateness for service or continuation of service and a disposition.

   • Crisis Intervention

   Crisis intervention services are available 24 hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in any setting. Services are directed toward the support of an individual who is experiencing an abrupt and substantial change in behavior related to a precipitating situation or a marked increase in personal stress. Crisis services are time-limited and are designed to prevent out of community placement or hospitalization. Interventions are used to de-escalate the situation while facilitating access to a myriad of crisis services when deemed necessary. The individual's behavioral health care advanced directive, if existing, is utilized to help manage the crisis.

   • Psychiatric Treatment

   Medical evaluation and medication management as well as assessment for appropriateness of treatment and monitoring an individual's status in relation to treatment and medication.

   • Nursing Assessment and Health Services

   Typically, face to face contact with a licensed nurse who provides nursing assessments to care for physical, nutritional and psychological issues, assess response to medication, consult with individual about medical, nutritional or health related needs, educate about potential side effects, perform venipuncture, provide assessment, testing and referral for an infectious disease.

   • Medication Administration

   The act of introducing a drug into the body of another person by any number of routes. Medication administration requires a physician's order and is not the supervision of self- administration of medication.

• *Pharmacy Services*

Either operate or purchase services to order, package, and distribute prescription medications. Assists individuals in accessing medication assistance programs and performs necessary lab work so that an individual is not refused service due to inability to pay.

• Case Management
This service consists of providing support, linkage and care coordination considered essential to assist the individual with improving their functioning, gaining access to necessary services and resources, and creating an environment that promotes recovery as identified in his/her individual recovery plan.

• Psychosocial Rehabilitation- Individual
Services include individual rehabilitative skills building considered essential in improving an individual's functioning level and learning skills that promote his/her access to necessary services and resources.

• Individual Counseling
A therapeutic intervention where in a qualified clinician employs techniques to assist a person in identifying or resolving personal, vocational, intrapersonal and interpersonal concerns.

• Family Training/Counseling
A therapeutic intervention with identified family populations directed toward the achievement of individual specified goals with an anticipated outcome of restoration, development, enhancement or maintenance of processing skills, healthy coping mechanisms, adaptive skills and behaviors, interpersonal skills, family roles and relationships, family understanding of mental *illness and/or substance related disorders.*

• Group Training/Counseling
Services provided in a group format with a skilled clinician or facilitator to address goals and issues the individual identifies as important to his or her recovery.

Specialty Services
• Assertive Community Treatment
Is a recovery focused, high intensity, community based service for individuals whose past or current response to other community-based intensive behavioral health treatment demonstrated minimal effectiveness, discharged from multiple or extended stays in psychiatric hospitals, frequently seen in emergency rooms, or crisis stabilization units due to SPMI, chronically homeless, and/or released from jails or prisons. A multidisciplinary team provides intensive, integrated and rehabilitative treatment and support within the community, and 24/7 face-to-face services must be available. This service is designed to decrease episodes of homelessness, hospitalizations, incarcerations, emergency room visits, and crisis episodes through comprehensive treatment that promotes community integration.

• Community Support Team
Is an intensive community-based service for individuals in rural areas who cycle in and out of intensive services and have not had their mental health treatment needs met via traditional outpatient services. This service is designed to decrease hospitalizations, incarcerations, emergency room visits, and crisis episodes through community integration. This service includes nursing services, care coordination, individual counseling, and skill building. Working in partnership with the core provider, this service is available 24/7 with emergency response coverage.

• *Peer Support Services/Forensic Peer Support Services*
Provide structured activities within a peer support center, inpatient hospital, CSC/Temp Observation, correctional facility, probation reporting center, or mental health treatment court that promote socialization, recovery, wellness, self-advocacy, development of natural supports maintenance of community living skills and successful community reintegration

• Psychosocial Rehabilitation-Group
Is a therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally occurring community settings. Services include group skills building, social problem solving and coping skill development, prevocational skills and recreational opportunities. It is offered twenty-five hours a week, for a maximum of 5 hours per Day.

• Supported Employment
Job development, placement and training for individuals with behavioral health challenges who desire competitive employment and need assistance to locate, choose, obtain, learn and maintain a competitive job in an integrated setting. Services include vocational interest and skills assessment, job search and maintenance supports that are necessary to perform and retain a particular job.

• Intensive Case Management
This is a recovery focused community approach that assists individuals with complex and high intensity care coordination of

service needs with moving between and among services necessary in order to remain in the community. Primary functions of this service include assessment of need, recovery planning, care coordination, access to resources, and monitoring. With a low staff to client ratio and a focus on rehabilitation, interventions are delivered primarily in the community rather than in office settings in order to coordinate needed mental health, physical health, and social services to support the individual's recovery process.

• Intensive Residential Services
Provides around the clock awake staff to assist individuals in successfully maintaining housing stability within the community, continue with their recovery, and increase self-sufficiency. A minimum of five hours of skills training is delivered each week to each individual enrolled.

• Semi-Independent Residential Services
The semi-independent residential service provides on-site staff available to deliver personal support and skills training at least 35 hours per week to each individual.

• Independent Residential Services
Scheduled residential services to an individual who requires a low level of residential structure to maintain stable housing. While there must be a written emergency plan that gives individuals access to a residential service specialist 24/7, the service requires a minimum of one face to face encounter per week.

• Housing Vouchers
The Georgia Housing Voucher assists individuals with an SPMI categorization in attaining and maintaining safe and affordable housing and supports their integration into the community. Supported Housing includes integrated, permanent housing with tenancy rights, linked with flexible community-based services that are available to individuals when they need them, but are not mandated as a condition of tenancy. All individuals with financial means are required to contribute a portion of their income towards their living expenses (tenant paid utilities, rent, and initial start-up expenses).

• Projects for Assistance in Transitioning from Homelessness (PATH)
PATH is a SAMHSA grant funded program designed to support the delivery of outreach and case management services to individuals with serious mental illness and those with co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. PATH's homeless outreach teams in Atlanta, Marietta, Columbus, Augusta, Valdosta, and Savannah outreach into the streets and homeless shelters to identify people who are chronically homeless and highly vulnerable to health risks. The teams use assertive engagement strategies to help people access housing and resources needed to end their homeless cycle.

Crisis Services
• Mobile Crisis
This service provides community-based face-to-face crisis response 24 hours a day, seven days a week to individuals in an active state of crisis that threatens their safety. Interventions include a brief, situational assessment; verbal interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural support systems; and referral to alternate services at the appropriate level.

• Crisis Stabilization Unit
A residential alternative to inpatient hospitalization, crisis stabilization programs offer psychiatric stabilization and detoxification services through medically monitored services to include psychiatric medical assessment, crisis assessment, support and intervention, medication administration, management and monitoring, brief individual, family or group counseling and medically monitored residential substance detoxification (ASAM level III.7-D.)

• Crisis Respite Apartments
Crisis respite apartments offer a brief period of respite for individuals needing a supportive environment. This service is available for individuals who are transitioning back into the community from a psychiatric inpatient facility, crisis stabilization unit (CSU) or behavioral health crisis center (BHCC)a. Crisis respite apartments include individualized engagement, connection to crisis planning, linkage to treatment, and other community resources necessary for the individual to safely reside in the community.

Inpatient Services
• State Operated Psychiatric Hospitals
DBHDD maintains accredited state operated psychiatric hospitals that provide intensive inpatient services for individuals who present an "imminent danger to self or others".

• Community Based Inpatient Psychiatric and Substance Detoxification Services
This is a short term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance abuse disorder. Georgia is moving away from hospital settings and toward social detoxification, assertive community treatment teams, mobile crisis response teams and crisis stabilization programs.

Substance Use Disorder Services

Substance Use Disorder treatment and recovery support services are contracted through Tier 1, Tier 2, Tier 2+ and specialty providers statewide. By contract, all providers offering the core benefit package must be co-occurring capable. Georgia provides

the following service array;

- Outpatient
- Residential
- CSU crisis services
- Detoxification
- Women's Treatment and Recovery Support Services (outpatient, residential and transitional)
- HIV EIS
- Peer Support services
- Addictive Disease Support Services
- C&A Clubhouses
- C&A IRT
- Adult Recovery Centers
- Opioid Maintenance Treatment

Child and Adolescent Mental Health Services
DBHDD provides a comprehensive community-based system of mental health care for children and adolescents with serious emotional disturbances (SED) and their families who need public services.
Below are brief descriptions of services provided to children and adolescents:

C&A Non-Intensive Outpatient Services
- Behavioral Health Assessment

Face-to-Face comprehensive assessment with the individual that includes the individual's perspective (and that of family and significant others as well as collateral agencies/treatment providers).

- Diagnostic Assessment

Psychiatric diagnostic interview examination completed in a face-to-face format (which may include the use of telemedicine) and may include family and other sources.

- Psychological Testing

Face-to-face assessment of emotional functioning, personality, cognitive functioning or intellectual ability using objective and standardized tools that have uniform procedures for administration and scoring, and utilizes normative data upon which interpretation of results is based.

- Crisis intervention

Designed to prevent out of home placements or hospitalization. Time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services.

- Medication Administration

An assessment, by the licensed or credentialed medical personnel administering the medication, of the youth's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the youth to the physician for a medication review. Education to the youth and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with youth's resiliency plan, must also be included.

- Nursing Assessment and Health Services

Requires face-to-face with youth/family/caregiver to monitor, evaluate, assess, and/or carry out a physician's orders regarding the psychological and/or physical problems and general wellness of the youth.

- Psychiatric Treatment

The provision of specialized medical and/or psychiatric services, including medication management and psychiatric psychotherapy, assessment, and monitoring, performed by a Board-Certified medical doctor licensed in the State of Georgia.

- Community Support

Rehabilitative, environmental support and resource coordination considered essential to assist a child/youth and family in gaining access to necessary services and in creating environment that promote resiliency and support the emotional and functional growth and development of the child/youth.

- Family Counseling

A therapeutic intervention or counseling service (successful with family populations) directed towards specific goals defined by youth and parent(s)/responsible caregiver(s) conducted by licensed staff, and specified in the Individualized Resiliency Plan.

• Family Training

Systematic interactions between identified individual, staff, and family directed towards restoration, development, enhancement, or maintenance of functioning of individual/family unit. This may include support of family, as well as training and specific interventions/activities to enhance family roles, relationship, communication and functioning promoting resiliency of family unit. This is directed toward the achievement of specific goals defined by the youth, parent(s), or responsible caregiver(s).

• Group Counseling

Group based therapeutic intervention or counseling service successful with populations, diagnoses, and needs. Directed toward the achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s).

• Group Training

Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of such things as problem solving skills, illness and medication self-management knowledge and skills, and healthy coping mechanisms.

• Individual Counseling

A therapeutic intervention or counseling service shown to be successful with identified youth populations, diagnoses, and service needs, provided by a qualified clinician. Techniques employed involve principles, methods, and procedures of counseling that assist the youth in identifying and resolving personal, social, vocational, intrapersonal, interpersonal concerns.

• Service Plan Development

Development of the Individualized Recovery/Resiliency Plan based on the results of the Diagnostic and Behavioral health assessments. Plan is required within the first 30 days of service.

• Community Transition Planning

Community Transition Planning (CTP) is a service provided by Tier 1, Tier II and IFI providers to address the care, service, and support needs of youth to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual, family, or caregiver with a minimum of one (1) face-to-face contact with the individual prior to release from a facility. Additional Transition Planning activities include: educating the individual, family, and/or caregiver on service options offered by the chosen primary service agency; participating in facility treatment team meetings to develop a transition plan

Specialty Services

• Intensive Family Intervention

Services intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification, or preventing the utilization of out-of-home therapeutic venues for the identified youth. Services are delivered utilizing a team approach and are provided primarily to the youth in their living arrangement and within the family system. This service includes crisis intervention, intensive supporting resources management, resource coordination, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services.

• Child and Adolescent Structured Residential Supports

Formerly Rehabilitation Supports for Individuals in Residential Alternatives, Levels 1 & 2, are comprehensive rehabilitative services to aid youth in developing daily living skills, interpersonal skills, and behavior management skills; to enable youth to learn about and manage symptoms; and aggressively improve functioning/behavior due to SED, substance abuse, and/or co-occurring disorders.

• Crisis Stabilization Units

This is a medically monitored residential treatment alternative to, or diversion from, inpatient hospitalization, offering short-term psychiatric stabilization and detoxification services.

• Community Based Inpatient Psychiatric and Substance Detoxification Services

A short-term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance related disorder.

• Mobile Crisis

This service provides time-limited crisis intervention in the community to reduce escalation of a crisis situation, relieve the immediate distress of individuals experiencing a crisis situation, reduce the risk of individuals doing harm to themselves or others, and to promote timely access to appropriate services for those who require ongoing mental health and co-occurring mental health and substance abuse services. This service is available 24 hours per day, seven days per week.

• Parent Peer Support Service- Group

This is a strength-based rehabilitative service provided to parents/caregivers in order to promote recovery by increasing the

family's capacity to function within their home, school, and community. Services are rendered by a Certified Peer Support-Parent

(CPS-P) and uses a group format.

• Parent Peer Support Service- Individual
This is a strength-based rehabilitative service provided to parents/caregivers in order to promote recovery by increasing the family's capacity to function within their home, school, and community. Services are rendered by a Certified Peer Support-Parent (CPS-P) and uses an individual format.

• Youth Peer Support- Individual
This is a strength-based rehabilitative service provided to youth who are living with a mental health, substance use, and/or co-occurring health condition. This one-to-one service rendered by a Certified Peer Support-Youth (CPS-Y) models' recovery by using lived experience as a tool.

• Psychiatric Residential Treatment Program (PRTF)
Psychiatric Residential Treatment Facility (PRTF) services provide comprehensive mental health and substance abuse treatment to children, adolescents, and emerging adults from ages six through twenty-one who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in an inpatient treatment setting and for whom alternative, less restrictive forms of treatment have been tried and found unsuccessful, or are not medically indicated. PRTF programs are designed to offer intensive, focused treatment to promote a successful return of the youth/emerging adult to the community.

• Intensive Customized Care Coordination
Intensive customized Care Coordination is a provider-based High-Fidelity Wraparound intervention, as defined by the National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is sought.

• Clubhouse Services
Resiliency Support Clubhouse Services for children and youth (ages 6-21) with behavioral health needs has been modeled after its counterpart within addictive diseases. These Resiliency Support Mental Health Clubhouses are designed to provide a comprehensive and unique set of services for children and families coping with the isolation, stigma, and other challenges of mental health disorders.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Georgia continues to advance evidence-based practices and promising practices. DBHDD has focused considerable attention on developing and implementing evidence-based practices within the mental health service system through dissemination of information and through pilot demonstration projects. As a result of this emphasis on best practice, the mental health system in Georgia has implemented Evidence-Based Practices (EBPs) in various parts of the state. The EBPs used within the state include Assertive Community Treatment (ACT), Individual Placement and Support (IPS) Supported Employment, Motivational Interviewing (MI), Housing First Permanent Supported Housing, and Integrated Dual Diagnosis Treatment (IDDT). Georgia's gender specific and age specific substance use treatment programs use evidence-based practices and fully integrates both mental health and substance use issues in the individualized recovery plan of those individuals who identify substance use as a barrier to recovery. DBHDD has spent several years providing statewide training to ensure competency in assessing and treating both mental illness and substance use disorders. In addition, Georgia has been a leader in the development of Peer Support Services and has implemented a Forensic Peer Mentor

initiative. DBHDD also contracts for the delivery of an array of crisis services. All of these services provide for a system of care for adults, support recovery of individuals, and provide opportunities for a meaningful life in the community. DBHDD currently contracts with providers for statewide delivery of ACT services in all 6 regions in the state of Georgia with funding and support for 22 state contracted and four Medicaid Rehabilitation Option (MRO) teams. DBHDD's contracted SE providers are funded to serve a total of 1,575 individuals each month. Since the significant FY15 increase in SE service capacity the department has continued to implement provider training on evidence-based practice SE (EBP SE) also known as the Individual Placement & Support (IPS) Model. Training has been delivered to contracted Supported Employment providers on Mental Health First Aid. Technical assistance was also provided during onsite IPS fidelity reviews of DBHDD's contracted providers.

DBHDD provides supported housing using the Housing First model. DBHDD is now the 8th largest provider of rental assistance in the state. As important as it is to assist individuals in obtaining safe and stable housing, it is equally vital to offer the supports and access to services that will help someone maintain their housing. This is the beauty of our system; DBHDD has a network of dedicated, hardworking behavioral health community service providers who deliver Community Support Team (CST) and Assertive Community Treatment (ACT) and Intensive Case Management (ICM) for persons with serious mental illness, supporting people with skills building and recovery planning in a way that helps people remain stable and housed in their community.

Georgia offers an array of Peer Support Services. Peer Support Programs provide structured group activities that are provided between and among individuals who have common issues and needs; are person-motivated, initiated and/or managed; and assist individuals in living as independently as possible.

For child and adolescent mental health, DBHDD OCYF has a school-based mental health services program, known as the Georgia Apex Program, which was developed in order to enhance access to the appropriate level of care; to provide early detection of child and adolescent behavioral health needs; and to develop and sustain coordination and collaboration between Georgia's community mental health providers and the school districts in their service areas. Georgia Project AWARE (GPA), funded by the Substance Abuse and Mental Health Services Administration, is designed to make schools safer and increase access to mental health services for children and youth. Both the State and the participating school districts have made an excellent start in addressing the mental health needs of children, youth, families and caregivers. The multiple components of the project including universal mental health screenings, a mental health referral process, Youth Mental Health First Aid (YMHFA) and school-based mental health services. Project Aware has worked collaboratively with DBHDD's Apex project,and trained together on the Interconnected Systems Framework (ISF), an integration of mental health into the Positive Behavioral Interventions and Supports framework.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), another SAMHSA funded grant, continues efforts to increase access to screening, assessment, and referral for appropriate services for children ages 0-8 in Muscogee County. DBHDD is partnering with the Department of Public Health (DPH) to implement the strategic plan. The project is currently focused on increasing mental health screening of young children in the school and early education settings using the ASQ and ASQ – SE (Ages and Stages Questionnaire – Social Emotional Assessment), increasing outreach to pediatricians to include mental health screening in their processes, and training the young child workforce on the social emotional development of young children. These goals are being accomplished through many local partnerships and the project has been able to establish many family, physician and community service champions.

In addition, DBHDD OCYF has two initiatives targeted to youth and young adults of transition age. The TAYYA initiative was designed to increase cooperation and collaboration across agencies to meet the needs of TAYYA with serious mental health conditions and their families. Funds available further the work of building infrastructure for non-billable time related to enhance outreach and engagement to emerging adults and build youth leadership/advocacy skills that is not reimbursable through Medicaid or other funds! They support best practices, cultural competence, support services that assist youth with independent living address needs for housing, employment, education, basic living skills, and social support not supported by other funding. The Emerging Adult Support Services (EASS) initiative is designed to create developmentally-appropriate and effective youth-guided local systems of care to improve outcomes for emerging adults with serious mental health conditions in areas such as education, employment, housing, mental health, and co-occurring disorders, and decrease contacts with the criminal justice system. OCYF supports EASS grants to Comprehensive Community Providers and "Not for Profit" providers to meet the following objectives: 1) Increase and improve cooperation and collaboration across agencies to meet the multiple and complex needs of emerging adults with serious mental health conditions and their families; 2) Enhance outreach and engagement to emerging adults and build youth leadership/advocacy skills; 3) demonstrate improving access and expanding the array of community-based, age-appropriate treatment, culturally and linguistically competent services and supports for emerging adults as well as their families.

DBHDD has also provided funding support to providers of child and adolescent mental health services for purposes of supporting activities that build on system of care infrastructure and support in local communities. DBHDD OCYF also provides funds for the System of Care Enhancement and Expansion Initiative. These awards are used to support system of care value oriented in child and adolescent mental health. These monies further the work of building infrastructure for

non-billable time related to family team meetings, LIPT meetings, and other consultative services with the other child serving agencies that are not reimbursable through Medicaid or other funds.

They support best practices, cultural competence, training, outreach activities to engage families, Non-Medicaid, non-billable transportation to and from treatment related activities, supplies and activities for individuals during groups and programming, community education activities on system of care work, and engagement activities with youth not supported by other funding.

The Office of Addictive Diseases (OAD) provides Core and Specialty Services. In addition, OAD continues to increase the array of treatment services available for youth with substance abuse issues. The services are: intensive residential treatment programs (IRTs) and the clubhouse recovery support services for youth. In addition, DBHDD funds two Adolescent Intensive Residential Treatment (IRT) Programs. The IRTs provide 24-hour supervised residential treatment for adolescents ages 13-17 who need a structured residence due to substance use disorders.

3. Describe your state's case management services

For adults with SMI, there are two types of case management: case management and intensive case management. Case Management consists of providing support, linkage and care coordination considered essential to assist the individual with improving their functioning, gaining access to necessary services and resources, and creating an environment that promotes recovery as identified in his/her individual recovery plan. Intensive Case Management is a recovery focused community approach that assists individuals with complex and high intensity care coordination of service needs with moving between and among services necessary in order to remain in the community. Primary functions of this service include assessment of need, recovery planning, care coordination, access to resources, and monitoring. With a low staff to client ratio and a focus on rehabilitation, interventions are delivered primarily in the community rather than in office settings in order to coordinate needed mental health, physical health, and social services to support the individual's recovery process.

For children and adolescents two types of case management services are offered: Community Support and Intensive Customized Care Coordination. Community Support is rehabilitative, environmental support and resource coordination considered essential to assist a child/youth and family in gaining access to necessary services and in creating environment that promote resiliency and support the emotional and functional growth and development of the child/youth. Intensive customized Care Coordination is a provider-based High-Fidelity Wraparound intervention, as defined by the National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is sought.

4. *Describe activities intended to reduce hospitalizations and hospital stays.*

Via contract with DBHDD, Behavioral Health Link (BHL) operates the Georgia's Crisis and Access Line (GCAL). GCAL's professional, clinical staff provide 24/7 telephonic crisis intervention and linkage to DBHDD services state-wide through a toll-free, confidential hotline available 24 hours a day, 7 days a week from anywhere in Georgia. It connects callers with a trained, professional who can help them get the services they need if they or someone they know or are caring for are in emotional distress, behavioral health crisis, a suicidal crisis, or even a crisis related to an intellectual/developmental disability.

Crisis stabilization units, behavioral health crisis centers, mobile crisis services and assertive community treatment assist persons through acute crises while remaining in the community. Although each of the six DBHDD regions has access to psychiatric hospital services for acute inpatient care for adults requiring hospital treatment, utilization of inpatient treatment is closely monitored. Every effort is made to prevent hospitalization through increased reliance on Community Crisis Stabilization Units (CSU), Crisis (walk-in) Service Centers (CSC), Behavioral Health Crisis Centers (CSC, Temporary Observation Unit, and CSU all on the same campus), and Crisis Respite Services. A network of Crisis Stabilization Units is spread across the state to help individuals in need of intensive interventions including; rapid assessment, stabilization, observation or brief admission. In community settings, the focus of CSU/BHCCs is provision of assessment, stabilization, medication monitoring, nursing services, linkage and referral and other treatments to support the individual in quickly returning to their own home in the community.
When individuals with SMI are hospitalized, they are offered peer support services from a Peer Mentor, who can assist them to actively engage in discharge planning and in making the transition to their new community home. Peer Mentors can help individuals set up household and make solid connections with service providers, and any other groups in the community with whom the individual would like to engage/participate.

The Hospital Recovery Planning Teams, Regional Field Office staff and Office of Adult Mental Health Transition Services are responsible for effective transition planning. This planning requires the development of partnerships between individual's hospital staff, field office staff and community care providers. All aspects of person-centered recovery planning rely on shared decision making and individually defined outcomes. Hospital Transition Specialists and Community Case Expediters in the Regional Field Offices are key players who rely on relationships they have established through collaborative efforts to help facilitate individuals obtaining needed services, and in crisis situations, can often divert individuals from the hospital to appropriate resources in the community. Hospital Transition Specialists and Community Case Expediters are perceived as the link between the hospitals and the community.

As it relates to children and adolescents, DBHDD has worked, successfully, to move from heavy reliance on acute care hospital services to increased community services. To that end, all state-operated long-term and short-term hospital units were closed some years ago. Comprehensive Community Providers (CCPs) are required to provide crisis services for youth receiving services. In addition, youth in need of acute care, crisis stabilization and treatment are being served through the array of Crisis Stabilization Units (CSUs) and mobile crisis services.

Narratve Question

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	393,035	138,551
2.Children with SED	99,707	46,463

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Prevalence estimates based on Federal CMHS estimating methodology. For adults with SMI, the prevalence rate of 5.4% is multiplied by the total adult population age 18 and over. For children and adolescents with SED, the prevalence rate of 8% is multiplied by the total child and adolescent population ages 9-17. For adults with SMI needing services from the public sector, Incidence is based on the % of population 18 and over under 200% of poverty. For children and adolescents with SED needing services from the public sector, incidence is based on the % of population ages 9-17 under 200% of poverty.

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

Narratve Question

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

Five of the six DBHDD regions have rural areas. As such, service to persons living in rural localities is of primary concern. Mental health service planning for rural areas occurs at a local level through the six DBHDD Field Offices. Field Offices, through input from their Regional Advisory Councils, public forums, public surveys, focus groups, and youth and family satisfaction surveys gather information to better plan for services in all areas of the state, particularly rural areas.
DBHDD contracts with providers to cover all areas of the state. Increasing access to services has been a major thrust of the DBHDD and its Regional Offices. Providers are required to deliver services out of the clinic setting. The Georgia Crisis and Access Line (GCAL) provides people seeking behavioral health services with information and access to comprehensive outpatient and crisis services throughout the state.

Transportation, however, can be a challenge. Medicaid enrolled individuals are able to utilize Medicaid transportation systems for travel to services; however, transportation services remain a challenge in more rural areas. Because many individuals with behavioral health needs lack access to natural supports to assist them in traveling to services many miles away from their homes, funding for transportation to Settlement services was approved by State legislators as a part of the original Department of Justice ADA Settlement Agreement. DBHDD has entered into a contract with the Department of Human Services to provide state supported transportation for individuals receiving the intensive community adult mental health services including: ACT, CST, CSU, ICM, CM, and Supported Employment services.

The Medicaid State Plan approved in May 2017 includes a new Consultation code approval to allow Tier I and Tier II BH Providers to bill when they engage with practitioners external to the system. The goal of the service is to allow these providers to access external and remote medical professionals to 1) promote health integration and 2) to access remote medical specialists to support and or refine diagnosis, prescribing, and treatment. This will assist rural providers in accessing specialists in other communities to support the individuals in those rural areas. Telemedicine continues to be an emerging avenue for dealing with the shortage of physicians and other practitioners in rural areas and Georgia is exploring additional ways to promote the effective use of telemedicine into the system of care. DBHDD worked with the State Medicaid Authority to add a rural modifier to ACT to promote statewide availability of ACT-type services. Therefore, DBHDD offers Community Support Teams (CST) to individuals living in rural areas.

Georgia continues to heavily invest in its Certified Peer Specialist workforce to promote recovery-based support capacity. In order to promote access, DBHDD has expanded CPS certification courses from metro Atlanta to the southern part of the state to promote rural workforce expansion. Additionally, the majority of peer wellness centers are located in rural communities and there are peer warm lines that operate 24/7. This is in addition to the GCAL which also operates 24/7 providing access to clinicians.

As relates to children and adolescents, one of the initiatives put forward by DBHDD to expand services throughout the state, including rural areas, is a school-based mental health project. This effort mentioned previously is referred to as Georgia Apex. DBHDD provides grant funding to 24 Community Service Boards and three additional providers to support the integration of community mental health professionals in the learning environment of targeted schools. Focusing on disparate populations, as well as local schools with identified need around school climate, the overarching goal is to increase access to mental health services and to ensure increased and sustained coordination between community mental health providers and local education agencies.

b. Describe your state's targeted services to the homeless population.

DBHDD has participated in collaboratives focused on homelessness. The Assistant Director of Adult Mental Health has been DBHDD's primary contact. In addition, to past involvement with coalitions in Georgia to address homelessness, she is a current member of the NASMHPD Housing Task Force. She also recently participated in the United States Interagency Council on Homelessness (USICH) Criteria and Benchmarks for Ending Family Homelessness: Stakeholder Input Session #3 (June 8, 2017). She is also responsible for PATH implementation.

It is the overall goal of the Projects to Assist in Transition from Homelessness (PATH) program to effectively and efficiently reduce homelessness for individuals with mental illness who do not access traditional mental health services on their own. The primary functions of PATH program are to identify, engage, and link homeless individuals to mainstream mental health services, housing resources, and other needed community resources. The strategy of linking engaged individuals to mainstream providers, rather than establishing a parallel service system for homeless individuals, conserves Georgia's scarce mental health resources. The success of the transition of individuals from PATH programs to mainstream services requires a good relationship between PATH funded agencies and mainstream agencies. PATH funding supports outreach services that goes into communities to identify and engage "literally" homeless individuals who are unable or unwilling to access mainstream mental health services on their own.

Georgia uses hired Certified Peer Specialists with homeless experiences to share their personal story of recovery to help establish client rapport and a client commitment to change. A large percentage of those receiving PATH services are successfully transitioned into mainstream service systems where they receive the resources necessary to end their homelessness. It is Georgia's vision for FY16 through FY18 to increase PATH effectiveness at ending homelessness for adults with mental illness. PATH Teams use the vulnerability index survey developed by Common Ground Institute, to identify those most at risk of dying on the street within one year to mobilize action to access housing and services. PATH Teams are encouraged to directly link those chronically homeless who are identified as most "at risk" to ACT Teams.

In partnership with the Department of Community Affairs (DCA), DBHDD works with core providers to identify target populations and areas of the state in need of Shelter plus Care housing. DBHDD also helps to establish supportive housing using Housing Choice and 811 Program vouchers and attaching mental health services and supports for those individuals who choose them. This has been an effective collaboration that helps individuals who are homeless to access safe, decent and affordable housing and receive community-based recovery services.

Providers are required to gather information on living situation upon enrollment in services. Providers under contract or agreement with DBHDD provide early intervention and mental health treatment services to identified youth with SED and their families who are at risk for homelessness or homeless and ensure that appropriate interventions are provided to meet the needs of this high-risk target population in Georgia. The Core Customer definition for eligibility for services identifies priority groups for state funded services. Youth who are homeless and who are at risk of homelessness are included in the priority group targeted for state funded services. Comprehensive mental health services are available in all regions for children and adolescents with SED who are homeless.

The DBHDD Regional Field Offices and their providers also participate in and support local efforts related to improving service delivery to homeless individuals.

c. Describe your state's targeted services to the older adult population.

The DBHDD Community MH Services Director and the Director of the Division of Aging Services (DAS) both served as members of the state team to develop plans to improve access to all services needed by older adults in Georgia and helped establish Georgia's network of Aging and Disability Resource Connections to serve as an entry way to long-term care support services for individuals with disabilities and the elderly. The goal for mental health improvement is to enhance the coordination and delivery of mental health services for older adults as it relates to the screening, referral, and treatment of mood disorders, primarily depression, as well as anxiety and co-occurring disorders.

DBHDD participates in the Georgia Coalition on Older Adults and Behavioral Health (GCOABH).
The Georgia Mental Health Consumer Network, the Fuqua Center for Late Life Depression, the DAS, and DBHDD partnered to develop a curriculum and trained Peer Specialists to work with older adults with mental illness on whole-health goals and activities.
The Department of Community Health utilizes a network of DBHDD behavioral health providers to deliver mental health services to nursing facility applicants and residents authorized through the Pre-Admission Screening and Resident Review (PASRR) Program. This brought DBHDD providers into the geriatric services market and, thus, encouraged development of expertise and capacity. Many of these same providers also deliver various home and community-based services to individuals in the DAS community Care Services Program who otherwise need institutional care in a nursing facility and who qualify or potentially qualify for Medicaid.

Currently, DBHDD has a Memorandum of Understanding with The Carter Center and the Fuqua Center for Late-Life Depression/Department of Psychiatry and Behavioral Sciences of Emory University to facilitate ongoing cross training of staff at DBHDD, its contracted behavioral health treatment providers, and DAS network of aging services providers in order to strengthen the existing system of care that serves older adults who have a mental illness or co-occurring disorder.

Narratve Question

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Fiscal Resources

The FY20 total annual budget for adult mental health in Georgia is $457,387,413 million. Of the total adult mental health budget, about 86% goes to fund community- based services. The remainder funds state hospitals. Of the adult budget 97% comes from state dollars, and 3% of adult community mental health is funded with federal dollars.

As part of the ADA Settlement Agreement, in FY12, DBHDD was appropriated $32,013,761 in the amended budget for the last quarter of the fiscal year; for FY 13 appropriated $52,356,013; in FY14 appropriated $73,913,477; in FY15 appropriated $97,997,387; in FY16 $2,313,015; in FY17 $6,133,276; in FY18 $7,756,876; and in FY19 the Department was appropriated $5,721,600. These funds support the expansion of community-based mental health services. In addition, part of this funding supports community transition needs of consumers being discharged from the state hospitals, particularly some transportation funds, etc., and there is increased staff capacity to meet the obligations of the Settlement Agreement.

The total amount of Mental Health Block Grant funding available for adult mental health services and administration in SFY20 is $15,178,419, and of this amount, $14, 421,645 is provided for Supported Employment, Peer Support Services and Mental Health Treatment Courts. An additional $783,016 is available to support other activities such as provider training, Georgia Mental Health Consumer Network for Peer Mentor development, the Peer Specialist Training and Certification Program, support to the Georgia Behavioral Health Planning and Advisory Council and state administration.

Over $60 million dollars is available to fund child and adolescent mental health services. Funding has supported an expansion of services including traditional outpatient services, community support, school-based mental health services, intensive family intervention services, mental health clubhouses, mobile crisis and crisis stabilization units. Historically, the majority of state and federal mental health block grant funds were allocated via contracts primarily to public providers of mental health services for the range of community-based mental health services. With the change to an FFS model for children and adolescents, DBHDD primarily has provider agreements for services and fewer contracts with grant in aid allocations.

For SFY20, there is $6,683,546 of MHBG funds available to support child and adolescent mental health services and administration. The majority of funding, $6,232,985 provided for child and adolescent services is contracted and supports the delivery of Care Management Entity Services (CME), Mental Health Clubhouses, a transitional age youth and young adult peer center, and first episode psychosis programs. The remaining amount of $450,561 is used to support training of providers and to support further development of family support/network organizations.

Staffing and Training

Community behavioral health services in Georgia are provided through a number of contracted public and private provider agencies. These are not state agencies and therefore we do not have specific knowledge about the numbers of staff of differing professional disciplines that are employed by each agency. Staffing requirements for services within the Georgia Behavioral Health system are established in both the DBHDD Provider Manual for Community Behavioral Health Services and the Medicaid Services Manual. Practitioners are divided into Professional and Paraprofessional categories and licensed mental health, practice under the scope of relevant practice laws. Paraprofessionals are those practitioners who are not licensed or certified to practice independently and all paraprofessionals must complete a standardized curriculum approved by the Department of Community Health and DBHDD. The training curriculum, Relias Learning (online learning), as a training tool for preparing paraprofessionals to work in the field of mental health; all paraprofessionals are required to complete a list of required courses shortly after hire. Demonstrated mastery of each topic area within the Standard Training Requirement is necessary in order for paraprofessionals to provide either state-funded or Medicaid-reimbursable services in Georgia. This training curriculum includes courses such as *Coordinating Primary Care for Needs of Clients; Mental Health Issues in Older Adult Populations; Cultural Issues in Mental Health* Treatment for Paraprofessionals; Bipolar Disorder in Children and Adolescents, Overview of Family Psycho Education – Evidence based Practices, Alcohol and the Family for Paraprofessionals, Co-Occurring Disorders; and an Overview for Paraprofessionals, Suicide Prevention, and Suicide the Forever Decision.

Each service definition contains specific staffing patterns that include the required level of supervision by a licensed practitioner, as well as staff-to-consumer ratios that meet standards of care. Urban areas of the state generally have more access to all categories of professional staff. The Health Resources Services Administration (HRSA) has designated many parts of the state as "Health Professional Shortage Areas," highlighting the fact that recruiting and retaining qualified staff presents a continuous challenge to rural providers. While shortages of all levels of professional staff exist within the Georgia system, concerted efforts are being made to secure qualified staff for services provision. Georgia strategically continues to grow the guild of Certified Peer Specialists to assist in promoting access and engagement while the workforce shortage persists. There is a shortage of Child Psychiatrists and psychiatric nurses in Georgia. Nurses and social workers are also under-represented within the public mental

health system, causing providers to focus significant resources on recruitment and retention activities. While shortages of all levels of professional staff exist within the Georgia system, concerted efforts are made to secure qualified staff for services provision.

According to the Georgia Composite Board there are 6,800 Professional Counselors; 872 Marriage and Family Therapists; 3,878 licensed Clinical Social Workers; 2, 732 licensed master's level Social Workers; 114 Associate Marriage and Family Therapists; 1,454 Associate Professional Counselors; and 2,382 Licensed Psychologists. Many rural counties report lack of child and adolescent psychiatry services. In addition, in looking at recent graduates in 2017 from the University System of Georgia, there were 354 graduates in Social Work; 40 graduates in Marriage and family Therapy; 12 graduates in Psychiatric Nursing; 3237 graduates in School Counseling; and 9 graduates in Clinical Psychology.

DBHDD has actively sought to improve its workforce to better deliver quality services. The driving force of DBHDD's system transformation is the continued development of the certified peer workforce. Agents of recovery and transformation, Georgia's CPSs inspire and support adult mental health individuals to recognize their dreams, preferences and strengths, and to learn skills to take responsibility for their recovery and creation of a meaningful life. Certified Peer Specialists (CPSs) have added tremendous value to the workforce as trained recovery specialists. CPSs are required staff for Assertive Community Treatment teams, Core Services and Peer Supports and Coordinated Specialty Care teams for the LIGHT-ETP for first episode psychosis. In addition, they are recommended staff for Psychosocial Rehabilitation. Certified Addiction and Recovery Empowerment Specialist (CARES) teaches individuals how to use their lived experience with recovery from substance use to support their peers in recovery. Individuals who complete the 40-hour experiential classroom work and pass the certification test become CARES. CARES and provide peer support services to people with substance use disorders in Georgia's continuum of care. Georgia also developed a training and certification process for parents of youth with behavioral health conditions. Individuals who complete this course and certification work as Certified Peer Specialists for Parents (CPS-P) in Georgia's continuum of care for children, youth and families. A curriculum has also been developed to certify peer specialists to work with youth (CPS-Y).

DBHDD recognizes the critical importance of staff development and training in strengthening mental health services in Georgia. The Offices of Adult Mental Health and Children, Young Adults and Families in conjunction with the Office of Human Resources/Learning (OHR) for the agency coordinates training and facilitates the many training and development activities offered through DBHDD. Some training initiatives are generated in response to gaps and challenges identified by various reviews and audits and others are developed as a result of quality improvement activities. All trainings are intended to improve the clinical skills of providers with whom the Department contracts for service delivery.

OHR has created DBHDD University and has implemented a Learning Management System (LMS) that provide online educational opportunities for both DBHDD staff and community providers. The LMS provides for course registration, record of course completions, assessment grades, transcripts, and printable course certificates. OHR facilitates many other training and development activities that are offered through DBHDD. Providers and system of care partners have received training in Trauma Informed Care, Transitions to Independence Process, Dialectical Behavior Therapy, Trauma-focused CBT, Crisis Planning and Safety Planning, Adolescent Co-Occurring Mental Health and Substance Use Disorders, Suicide Prevention of at-risk populations, Mental Health Training for Spoken Language Interpreters and Training for Mental Health Clinicians in Use of Spoken Language Interpreter Services, Cultural Competence and System of Care Leadership and Approaches. In addition, annually, OHR provides support to the Division of Behavioral Health for development and implementation of the Behavioral Health Provider Symposium. This symposium is held to present the latest innovations in service delivery, best practices, shared values, philosophies, expectations, and training related to the service system guidelines and policies. All providers are required to attend.

DBHDD also funds and sponsors an Annual Georgia System of Care Academy with the most recent one, System of Care Academy X, held in June 2017. The Annual System of Care Academy provides a shared value, principles, and practice focused conference. It is held each summer and key staff from DBHDD, Community Mental Health, Addictive Diseases, DFCS, GaDOE, DJJ, GVRA, DPH, DECAL, DCH programs, other professionals, families and youth from across the state are invited.

Emergency Services Worker Training

All services in the Georgia DBHDD system are provided under contract or agreement with private or public providers of behavioral health services. Local providers work with emergency personnel such as Sheriff's Departments, Hospital Emergency Rooms and county jails on issues related to individuals with behavioral health needs. The local providers educate these responders on the needs of individuals as well as on the services available through their agencies. In particular, in areas that are more rural, provider staff develops relationships with local hospital emergency rooms and other responders to keep them apprised of the unique needs of persons with mental illness and serious emotional disturbance in emergency situations. In the more metropolitan regions, the providers sometimes contract with outside vendors to do training of emergency personnel.

Behavioral Health Link provides information and marketing materials regarding the Georgia Crisis and Access Line to hospital emergency room personnel and local law enforcement staff. The intent is for all emergency services personnel to be informed of the availability and process for accessing 24/7 crisis response for any individuals in a crisis related to mental illness or addictive diseases.

DBHDD blends funds with the Georgia Public Safety Training Center (GPSTC), to provide CIT training to Georgia's law enforcement officers using a curriculum that blends best evidence based practices from the new Bureau of Justice Assistance (BJA) CIT Model,

the Memphis, Tennessee CIT model, and data gained from CIT practice in the field since 2006. In an effort to reduce the stigma associated with mental illness, the Georgia CIT Program's vision is a Georgia where citizens with serious mental illness receive medical treatment in lieu of incarceration. Georgia adopted a top-down approach to training law enforcement by forming a collaborative with executives from key departments of state government, mental health providers and advocacy organizations.

In response to requests from local law enforcement agencies wanting to increase their numbers of officers with at least some knowledge of behavioral health issues and response prior to their being able to attend the full week-long CIT course, NAMI facilitated a new DBHDD-funded Introduction to Behavioral Health Crisis curriculum--seven (7) 16-hour courses for Law Enforcement Officers waiting to attend the 40-hour CIT class, and eight (8) 8-hour courses for First Responders and 911 Operators— The goal and objective of the new training is to provide an in-service introductory course on behavioral health crisis for law enforcement officers as a precursor to the Georgia CIT Program.

In FY17, DBHDD's OCYF, entered a separate contract with NAMI Georgia, to provide CIT for Youth Training. In general, CIT for Youth programs train officers on adolescent brain development and how mental health symptoms manifest with youth. In addition, the training helps officers and school staff work to better address mental health concerns in a school setting. CIT for Youth programs teach law enforcement officers to connect youth with mental health needs to effective services and supports in their community. The goal is to intervene early in emerging mental health issues and prevent youth from becoming involved in the juvenile justice system. The programs work with schools, school-based police officers, children's mental health providers and parents to accomplish these goals.
During 2017, NAMI held several stakeholder meetings with over 175 stakeholders in Region 3 (Albany State University), Region 4 (Albany), and Region 5 (Savannah & Vidalia) to identify the barriers schools have connecting their students and resources available for them. Over 100 participants were trained on the CIT-Y, which included Atlanta Public Schools Police Department and Albany Police Department as well as a Train the Trainer training to the Atlanta Public School Department of Education.
The Georgia Bureau of Investigation (GBI) has incorporated a module on trauma into its monthly training for new Crisis Intervention Team (CIT) State Patrol officers across the state. The training includes interviews with actual individuals who have received services for PTSD, education on the signs and symptoms of trauma and other mental illnesses, as well as de-escalation techniques for use in working with persons in crisis related to trauma. A goal of the CIT training program is that officers understand that involvement in many infractions of the law may be a result of a person's trauma history or failure to receive proper trauma-informed treatment, rather than a result of intentional wrongdoing.

DBHDD's Assistant Director of Adult Mental Health Services is the Program Manager for the GPSTC contract and one of AMH's Behavioral Health Treatment Court Liaisons is a member of the GPSTC Crisis Intervention Team Training Advisory Board. DBHDD also has a Disaster Mental Health Coordinator's (DMHC) position which is fully funded by the Georgia Department of Public Health. DBHDD's DMHC works with the Georgia Emergency Management Agency and other emergency preparedness agencies to ensure that the behavioral health needs of Georgia residents are included in state-level plans. The DBHDD Regional Hospitals and provider agencies are members of Regional Emergency Preparedness Healthcare Coalitions throughout the state and they participate in exercises with local healthcare and emergency preparedness partners. Georgia's disaster mental health website at www.georgiadisaster.info contains information and resources on disaster mental health planning. DBHDD has a continuity of operations plan policy for its state office and policy that requires continuity of operations for all contracted providers. Disaster mental health training and exercises takes place throughout the state several times a year.

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Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

During the SFYE 06/30/2019, DBHDD performed at least one quality review on >99% of behavioral health providers. Some of the areas considered in these comprehensive reviews include the following:

- Assessment & Treatment Planning
- Billing Validation
- Compliance with Service Guidelines
- Consumer Choice
- Person-Centeredness
- Whole Health
- Safety
- Consumer Rights
- Community Life

Aggregated data from these comprehensive reviews is used to identify and create training for providers, as well as inform Quality Improvement projects, suggest changes to policy, and ensure alignment of review activity with provider manuals.

Changes to the comprehensive quality review process have been implemented in SFYE 6/30/19, with an effective date of 7/1/2019. These changes are focused on increasing reliability and validity of data collected during the review process, as well as reducing provider burden.

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No
5. Does the state have any activities related to this section that you would like to highlight.

   DBHDD has a policy that requires all community providers to screen and assess for trauma and to connect individuals to appropriate treatment. Since FY16 DBHDD contracted providers have maintained implementation of a functional assessment tool, the Adult Needs and Strengths Assessment (ANSA). The ANSA and the child and adolescent version, the CANS, are multi- purpose tools developed for behavioral health services to support decision making, level of care and service planning, including the application of evidence-based practices, to facilitate quality improvement initiatives, and to allow for the monitoring of service outcomes. These tools require providers to assess the following trauma-related items:
   Adjustment to Trauma

- Sexual Abuse
- Physical Abuse
- Emotional Abuse
- Medical Trauma
- Natural/Manmade Disaster
- Witness/Victim to Family Violence
- Witness/Victim to Community Violence

Many of DBHDD's community providers serve foster children under agreements with the DCH/Division of Medicaid Care Management Organization contracts. The state child welfare agency, the Division of Family and Children's Services (DFCS), changed its policy in July 2012 related to trauma assessments. All youth coming into care must have trauma assessments.

DBHDD promotes use of evidence-based trauma-specific interventions across the lifespan through training. The DBHDD contracts with service providers require that provider staff receive appropriate in-service training. Training is provided through various statewide efforts including the annual Georgia School for Addiction Studies (GSAS) conference that offers the opportunity to increase provider capacity on a variety of behavioral health topics, including trauma-specific interventions. For example, the 2017 Eleventh Annual GSAS conference held August 28-September 1, 2017, included a trauma track and seven trauma-specific training offerings: Thief and Liar: Training Informed, Integrated Intervention; Shining Through the Wounds: Trauma-Informed Treatment and care; Overcoming Trauma with Tensegrity; Trauma, the Brain, and Co-Dependency; Healing Trauma Through Art; Domestic Violence and Substance Abuse: Understanding the Cycle; and Burnout and Secondary Trauma. In addition, the annual System of Care Academy and annual Behavioral Health Provider Symposium are designed to inform and train current Behavioral Health providers regarding best practices in the delivery of community mental health care.

Through the SAMHSA System of Care Expansion and Implementation grant, DBHDD in partnership with the Georgia State University Center of Excellence provides Trauma Informed Care training throughout the state. The training is targeted to all DBHDD behavioral health providers for child and adolescent services as well as other child-serving agencies. Staff from DBHDD and the Center received training to become trainers from the National Child Traumatic Stress Center.

Through the SAMHSA System of Care Expansion and Implementation grant, DBHDD in partnership with the Georgia State University Center of Excellence is providing Trauma Informed Care training throughout the state. The training is targeted to all DBHDD behavioral health providers for child and adolescent services as well as other child-serving agencies. Staff from DBHDD and the Center received training to become trainers from the National Child Traumatic Stress Center. In the previous two years, the Clinical Director of the Office of Children, Young Adults, and Families (OCYF) co-facilitated two-day trainings offered to every region in the state. In June of this year, in response to popular demand, the Clinical Director again co-facilitated trauma-informed systems training in two different regions of the state. As we are now considering sustainability plans, the Clinical Director will review and consider the trauma training protocol being implemented by our child welfare partners, to determine the feasibility of blending the two programs.

Trauma informed care has also been provided for the Office of Addictive Diseases" CABHI-COM funded Home for Recovery project. Staff have been trained in and are implementing the Trauma Recovery Empowerment Model (TREM) and TREM for Men by the project's two providers. The project provides recovery support for individuals 18 years of age and older who have been chronically homeless, are currently in permanent supportive housing and that have SUD, MH or co-occurring SUD and MH. The project includes a focus on serving veterans. Trauma informed trained project staff include Certified Peer Specialists (CPSs) and Georgia Certified Addiction Recovery Empowerment Specialists (CARES).

Each of Georgia's PATH Teams is required to hire a CPS with lived experience of homelessness, a circumstance that often results in exposure to trauma. Similarly, Georgia's 22 Forensic Peer Mentors, are CPS's with lived experience involving mental health and/or substance use history combined with past involvement with the criminal justice system, including incarceration, which often results in post-incarceration syndrome, triggered by living in an oppressive and often violent environment. CPS working in both of these roles are positioned to contribute to the development of trauma-informed organizations and the recovery of their peers currently in treatment. Additionally, CPS contribute their lived experiences while working in multiple arenas of the Adult Mental Health array of community services. There are peers who work on all 26 ACT teams, as well as on some community support teams, and on supported employment teams and throughout out crisis system; in behavioral health crisis centers, crisis stabilization units and mobile crisis response service. In FY 2019, the Office of Adult Mental Health provided a comprehensive trauma informed care training series for providers of these intensive community services.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

   For individuals on probation or parole, the Department of Community Supervision (DCS) has established Specialized Mental Health Probation Officers, to provide more targeted supervision. DBHDD and the DCS are working collaboratively to develop a pilot to share resources in the community such that DBHDD can serve as consultant for these specialized officers and these officers may assist DBHDD as they work with mentally ill individuals in the community who may still pose a risk, but whose legal situations permit access to community behavioral health services.

   In SFY15 DBHDD signed a Memorandum of Agreement with GDC and DCS to further promote successful re-entry into the community for individuals with serious mental illness or co-occurring substance use disorders. DBHDD contracted with the Georgia Mental Health Consumer Network (GMHCN) to staff a pilot Forensic Peer Mentor Program. Certified Peer Specialists (CPS)s and/or Certified Addiction Recovery Empowerment Specialists (CARES, aka CPS-AD) were provided 40 hours of additional training to support individuals with behavioral health conditions to successfully transition from incarceration in prison to community living. Individuals identified by behavioral health clinical staff at program sites (state prisons, Day Reporting Centers (for probationers), and state hospital forensic units, who elected to participate, are paired with a Forensic Peer Mentor (FPM) who

offers assistance with self-direction in choice of housing, employment, service providers, etc. in transition planning, and in

executing the plan to ensure connection with community services, employment and development of natural supports. The pilot program has evolved and been sustained and in FY17 21 Forensic Peer Mentors provided over 16,000 transition planning and support sessions to 246 Returning Citizens.

Additionally, DBHDD contracts with three community providers that employ FPMs to work in local Mental Health Treatment Courts. The FPMs are integral parts of the multidisciplinary treatment court team and vital support persons for individuals who have been diverted from incarceration and agreed to participate in treatment services.

In September 2016, then Governor Nathan Deal initiated additional training for law enforcement which included the CIT Program. The Georgia Public Safety Training Center (GPSTC), the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Georgia chapter of the National Alliance on Mental Illness (NAMI), partnered to expand Georgia CIT from the former DBHDD/NAMI collaboration for delivery of CIT to implementation of a more statewide expansion of the CIT Program, with the infusion of additional state dollars to the GPSTC budget (in addition to what DBHDD was already providing)

This expansion has increased the number of training opportunities law enforcement will receive regarding the various types of mental illnesses, addictive diseases, and other disorders including Autism and Alzheimer's disease. The GPSTC, DBHDD, NAMI, and other mental health advocates are collaborating to provide this training to law enforcement statewide. This collaboration speaks highly to the commitment these agencies have in serving and protecting all citizens of Georgia. It is the belief of these agencies, that joining efforts in this common cause will not only help those who may be in a mental health crisis, but to also provide the best service to the communities. The GPSTC and DBHDD's goal is to provide approximately 200 CIT classes statewide in a given year. This expansion will allow more law enforcement agencies and officers to have an opportunity to receive this critical training.

DBHDD is working with the Courts and GDC to ensure that individuals who are able to be diverted from, as well as individuals transitioning from, correctional institutions have access to Supportive Housing and the current array of behavioral health services. DBHDD continues to meet with the Courts and the Georgia Department of Corrections (GDC) to provide information about DBHDD's current array of evidence-based services, as well as how to access those services in a timely manner. In addition, organic local collaborations have occurred between local courts and community behavioral health providers.
In response to requests from local law enforcement agencies wanting to increase their numbers of officers with at least some knowledge of behavioral health issues and response prior to their being able to attend the full week-long CIT course, beginning in June of 2015, NAMI Georgia in collaboration with Georgia CIT Partners provided a new DBHDD-funded eight (8) hour class to law enforcement agencies that served as an introduction to mental illness and other behavioral health disorders for officers. The goal and objective of the new Introduction to Behavioral Health Crisis training is to provide an in-service introductory course on behavioral health crisis for law enforcement officers and first responders, including 911 Call Center dispatchers.
In addition, in FY17, DBHDD's OCYF, entered a separate contract with NAMI Georgia, to provide CIT- Youth Training. In general, CIT -Youth programs train officers on adolescent brain development and how mental health symptoms manifest with youth. The training helps officers and school staff work to better address mental health concerns in a school setting. CIT-Youth programs teach law enforcement officers to connect youth with mental health needs to effective services and supports in their community.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   - a) ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) ☑ Psychiatric Advance Directives
   - c) ☑ Family Engagement
   - d) ☑ Safety Planning
   - e) ☑ Peer-Operated Warm Lines
   - f) ☑ Peer-Run Crisis Respite Programs
   - g) ☑ Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) ☑ Assessment/Triage (Living Room Model)
   - b) ☑ Open Dialogue
   - c) ☑ Crisis Residential/Respite
   - d) ☑ Crisis Intervention Team/Law Enforcement
   - e) ☑ Mobile Crisis Outreach
   - f) ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) ☑ Peer Support/Peer Bridgers
   - b) ☑ Follow-up Outreach and Support
   - c) ☑ Family-to-Family Engagement
   - d) ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
   - e) ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

DBHDD has a live referral board and census for the crisis system. While some states run a bed registry, very few have a live census and can determine the number of individuals waiting for care and the live bed availability across the system. The referral board is in the process of an update, funded in part by a TTI grant through NASMHPD, that will allow portal access by emergency rooms to not only post a referral, but to communicate electronically with the receiving facility instead of waiting for an arranged time for a telephone consultation. The live referral board allows for quicker access to the right level of care for individuals waiting for treatment as well as provides essential data that helps Georgia forecast and improve the crisis system.

DBHDD contracts for provision of a comprehensive crisis system that includes statewide mobile crisis response, and community-based crisis stabilization units and walk-in adult behavioral health crisis centers. These services are effective in responding to individuals in crisis via provision of de-escalation, , assessment and triage, stabilization and linkage to appropriate after-care services. DBHDD has recognized the increased need for Peer services in the Crisis System. Persons with lived experience are being added to the Behavioral Health Crisis centers and all units have been trained on a peer first- peer last model of engagement. DBHDD contracts for provision of services that support prevention and postvention of crises, including peer wellness and respite centers and crisis respite apartments. Peer wellness and respite centers are peer-run and allow individuals access to necessary non -crisis peer supports as a component of their ongoing recovery. Crisis respite apartments provide a short-term supportive community residential setting that facilitates transition back into the community following a crisis such as hospital, CSU or BHCC admission.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	◉ Yes ○ No
b)	Required peer accreditation or certification?	◉ Yes ○ No
c)	Block grant funding of recovery support services.	◉ Yes ○ No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	◉ Yes ○ No

2. *Does the state measure the impact of your consumer and recovery community outreach activity?* ○ Yes ◉ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery for adults living with a SMI will be different for each person, depending upon their goals, strengths, supports, interests, and available community resources. Some use medication, while others rely on peer support and illness self-management and wellness skills. Some may continue to experience symptoms; others may not. The important thing is that individuals are leading meaningful lives, engaged with the community and natural supports.

DBHDD offers a variety of recovery support services, including connection to affordable housing, vocational rehabilitation and supported employment services. Certified Peer Specialists (CPSs) are the foundation of DBHDD's recovery supports. CPSs with specialized training offer Peer Mentoring to individuals transitioning from hospitals or prisons. Peer Support Programs and Individual Peer Support Services are available in the formal service system to promote self-directed recovery and help individuals explore personal meaning, tap into strengths, establish natural support systems, and work toward achievement of life and recovery goals. Whole Health & Wellness Peer Support services are offered to individuals who wish to work on overall health goals (i.e. depression and diabetes management). Training in the development and use of Wellness Recovery Action Plans is also available to individuals within and outside of the formal treatment system.

Outside the traditional system of care, DBHDD contracts with the Georgia Mental Health Consumer Network (GMHCN) to operate the Georgia Certified Peer Specialist training & certification program; provide education on self-directed recovery, tools and skills; and provide community-based peer support groups and drop-in centers. Each August over 500 individuals attend the 3- day statewide MH consumer conference. Twice a year, the Georgia Peer Support Institute offers, to a smaller group, a 3-day immersion in the hope of recovery and self-direction. Wellness Recovery Action Plan (WRAP) training is available to peers across the state, in and outside of traditional service settings. Double Trouble in Recovery peer support groups are offered across the state to individuals with co-occurring mental and substance use disorders.

Telephonic Peer Support is available 24/7/365; and daily wellness activities are offered on a drop-in basis, at the five consumer-operated Peer Support, Wellness & Respite Centers (PSWRCs). The PSWRCs also offer peer respite services as an alternative to psychiatric hospitalization.

Recovery for children with SED and their families means that the children and families are empowered with the knowledge, skills, resources and supports to function within their home, school, and community, and the youth are able to achieve developmentally appropriate milestones and self-determined goals toward adulthood. While DBHDD has been supporting the organization of Federation of Families chapters across the state, and conducting the Youth Leadership Academy to empower parent and youth advocacy and leadership, the most comprehensive recovery support is the cultivation of a certified peer workforce for parents and youth. Certified Peer Specialist-Parents (CPS-Ps) have been trained to use their experience raising a child with BH/SED to encourage, engage and empower parents by enhancing community living skills, developing natural supports, navigating the system of care, and using interventions that support the youth's natural environment. Certified Peer Specialist-Youth (CPS-Y) have been trained to use their experience of being in recovery from a childhood BH/SED condition to help encourage, engage and empower the youth to understand differing views and more effectively communicate their needs and desires to parents and members of the system of care; as well as how to engage with friends and supporters at school and in the community. Cultivation of the parent and youth peer support services has led to an increase in parent and youth leadership, advocacy and involvement in the system of care, as well as the growth of 28 Federation of Families chapters and 3 Youth Move organizations.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery from substance use disorders will vary, depending upon the path individuals choose. Some want complete abstinence; others may opt for medication-assisted treatment for detoxification, on-going maintenance, and/or to manage the symptoms of a co-occurring mental disorder.

While DBHDD offers Recovery Residences to help recovering individuals get back on their feet after treatment, the foundation of recovery supports is the CPS-AD, who are trained to use their lived experience with a substance use disorder to provide peer support to those seeking to maintain their recovery. In the formal treatment system, CPA-AD's run AD Peer Support Programs and provide Individual Peer Support services which promote recovery, advocacy, relationship enhancement, self-awareness, values and self-directed care. Recovery Support Centers provide hope, healing and wellness in a safe and comfortable environment, and utilize peer support to help individuals who drop-in, work on their life goals and connect to vocational, educational, employment, transportation, case management, family support, life skills and other types of resources.

SAMHSA's Opioid Crisis grant is allowing Georgia to expand the reach of peer support by funding a 24/7/365 peer support warm

line for individuals seeking treatment or recovery services ; requiring providers of expanded Medication Assisted Treatment to employ CPS-AD's to support individuals in exploring other pathways to recovery; implementing two peer support programs in emergency rooms to engage with individuals treated for opioid or other drug abuse and connect them to treatment and recovery resources. The presence of CPS-AD's in Georgia's treatment system and communities is strengthening the voice of the recovery community at state and local levels; supporting DBHDD in Recovery Community development; advancing the hope and understanding of recovery, and ensuring that recovery supports and services are available and accessible to all who need and want them.

5. Does the state have any activities that it would like to highlight?

DBHDD has been working with Joel Slack for a number of years to develop the Respect Institute of Georgia. This initiative emphasizes the power of being treated with dignity and respect, and teaches adults to tell their recovery story to various audiences. Over the past 2 years DBHDD has created a RESPECT Institute specifically designed for youth and young adults. This program provides 8 -10 youth and young adults ages 16-27, with the skills and coaching necessary to transform their personal and family stories, behavioral health service experiences, and recovery journey into educational and inspirational presentations of varying amounts of time, for diverse audiences. The Youth RESPECT Institute graduation is strategically scheduled to coincide with the Parent & Youth CPS training and technical assistance events. This training day combines youth recovery stories with an orientation of the emerging Medicaid service for Parent & Youth Peer Support. DBHDD Child and Adolescent Providers receive a preview of the service including understanding the competencies, service definition, billable codes, and notes. Providers can also expect to learn about:

- Preparing organizational culture, patterns, habits, and structures to contribute to the successful inclusion of peer support partners:
- Identifying potential candidates to apply for the Parent/Youth CPS training;
- Developing effective partnerships between peer and professionals;
- Receive highlights from Georgia's new curricula for Parent and Youth Peer Specialist Certifications;
- Understanding the unique roles of the Certified Peer Specialist-Parent (CPS-P) and Certified Peer Specialist – Youth (CPS-Y).

In September 2016, the DBHDD and its Office of Addictive Diseases was awarded a second three-year SAMHSA Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant. CABHI is jointly funded by the Center for Substance Abuse Treatment and the Center for Mental Health Services. The purpose of the DBHDD Home for Recovery CABHI project is to increase capacity in Georgia to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based recovery support services and peer supports and peer navigator services and other critical services to persons who are experiencing chronic homelessness with substance use disorders, severe mental illness or co-occurring substance use and mental disorders and who are in Shelter Plus Care or in other permanent housing slots. Project services are implemented by two of DBHDD Tier Comprehensive Community Providers, Cobb Douglas Community Service Board and Highland Rivers Health. Project participants, who are chronically homeless and have a substance use disorder, severe mental illness and/or co-occurring mental illness and substance us, receive recovery-oriented services including certified peer specialist services. The project uses the Trauma Recovery Empowerment Model (TREM) as one of its evidence-based practices.

In April 2017, DBHDD was awarded a State Targeted Response to the Opioid Crisis Grant by the Substance Abuse and Mental Health Service Administration (SAMHSA). The funding, totaling nearly $11.8 million, is provided for in the 21st Century Cures Act of 2016, and will support DBHDD and other community providers combatting opioid addiction through prevention, treatment, and recovery services. Recovery activities include implementation of peer specialist programs in two hospital emergency departments; incorporating certified peer specialists in identified emergency departments to ensure immediate connection for individuals who have experienced an opioid overdose or individuals with an opioid use disorder who are presenting for services; establishing funding to support the infrastructure of recovery transitional housing; expanding/developing recovery support services for individuals with opioid use disorder; and implementing a warm line, run by peers, for individuals struggling with opioid use disorder.

The annual Georgia School of Addiction Studies (GSAS) offers a unique opportunity for professional development, information exchange, and networking. It is designed to address the need for knowledge and skill development through advanced training. The purpose of the GSAS is to: 1) foster and maintain the integrity of substance abuse related services by assisting in providing continuing training and education programs for more than 500 human service providers each year whose duties include prevention, intervention, treatment, law enforcement, child welfare, victim's services, law enforcement, court system, education, and rehabilitation or related social services; 2) to promote a broader understanding of, response to, and acceptance of, the process of addiction and its impact in areas of health, family, community, crime and the workplace; and 3) to encourage the exchange of professional knowledge through educational conferences and programs of continuing.

Six DBHDD Office of Addictive Disease staff and two members of the Office of Behavioral Health Prevention staff serve on the Georgia School of Addiction Studies Board and help plan the conference program agenda. The five-day annual conference includes prevention, treatment and recovery presentations and workshops. The 11th Annual Conference, held August 28 through September 1, 2017 includes the following training events: Finding Hope in the Darkest Places; From the Darkness of Columbine and Addiction to the Light of Recovery (presented by Columbine survivor); Words Matter – Let's Talk About Recovery; Youth in Peer Leadership and Small Group Setting; Ready, Set – Change! Navigating Life During the Recovery Process; Recovery Ready Ecosystems – Bridging Prevention, Treatment, and Recovery; and Families in Crisis – Working with Families in Recovery.

Please indicate areas of technical assistance needed related to this section.

We are in the exploratory stages of developing an add-on certification of Older Adult Peers. We would be open to any TA in this area.

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Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

DBHDD is actively engaged in a wide range of activities to address community integration as a result of the Department of Justice v. Georgia Settlement Agreement and subsequent Settlement Agreement Extension. Since October 2010, DBHDD has expanded the availability of adult community based services for individuals with mental illness to include 22 Assertive Community Treatment (ACT) Teams, 10 Community Support Teams (CST), 14 Intensive Case Management (ICM) Teams, and 52 Case Managers (CM), a peer supports program that serves more than 835 individuals annually, 6 Behavioral Health Crisis Centers, a statewide Crisis and Access Line that is accessible 24/7, 24 Crisis Respite Apartments, and a supported employment program serving more than 2,000 individuals in FY19. DBHDD's contracted ACT teams provide services and supports to approximately 2,500 persons with a serious and persistent mental illness categorization annually. Individuals enrolled in ACT or CST services maintain a housed/non-homeless average of 95%. Additionally, DBHDD's contracted providers of Supported Employment assist persons in exploring vocational opportunities and obtaining jobs, while maintaining a competitive employment rate of 49% for enrolled individuals.

To promote housing availability, DBHDD contracts for the operation of more than 1,900 Community Residential Rehabilitation units and has provided access to supported housing to more than 4,000 persons with a serious and persistent mental illness through the DBHDD funded Georgia Housing Voucher Program.

The Georgia Department of Behavioral Health (DBHDD) and Georgia Department of Community (DCA) affairs signed an intergovernmental Memorandum of Agreement in 2015 to expand the provision of independent supported housing and support community integration for those meeting the settlement agreement criteria. A Unified Referral (UR) process was created to streamline housing referrals directly from DBHDD state hospitals, crisis centers, community-based outpatient services and other access points, allowing eligible individuals to be considered for multiple rental assistance programs. DCA updates DBHDD and its

providers on any new housing resources that become available on a regular basis. Georgia was awarded $14.4 Million from HUD to provide long term project based rental assistance to person with disabilities who are a part of the DOJ settlement agreement. Housing units are attached to new and existing tax credit apartment developments around the state (this is not he portable voucher system). Georgia was given a HUD Housing Choice Preference (formerly known as Section 8) for individuals who meet eligibility under the DOJ settlement agreement.

Some of these housing resources, such as HUD 811 vacancies, are provided on an ongoing basis as they become available. Through the Unified Referral Process (URP) potential housing options for individuals are identified by DCA on a weekly basis and communicated to DBHDD regional staff and providers. Other resources are presented as they become available on a cyclical basis, such as Emergency Solutions Grants (ESG), Housing Opportunities for Persons with AIDS (HOPWA), HUD Continuum of Care (including Shelter Plus Care and Coordinated Entry), and the Reentry Partnership Housing Program (RPH), that have annual or bi-annual application cycles for funding.

Some recent and ongoing ways these housing updates have occurred include:
• DCA weekly staffing meetings of individuals that come through the URP system. The HUD 811 Coordinator at DCA conducts a weekly staffing of all referrals from DBHDD providers utilizing URP. These staffing meetings include a variety of DCA OHSN staff that work directly with HUD 811, ESG, HOPWA, Continuum of Care (CoC), Shelter Plus Care (S+C), and RPH. For homeless individuals, referrals are made to the Coordinated Entry systems in their communities. In addition to the programs, referrals are also made, as appropriate, to housing programs for veterans like Supportive Services for Veteran Families (SSVF) and VASH, domestic violence housing providers and shelters, and for Settlement eligible preference Housing Choice Vouchers (HCV).
• The HUD 811 Coordinator sends weekly updates to DBHDD staff, Regional Coordinators and providers listing all vacancies available in the program, the property locations, and the timeframe in which they need to be filled.
• DCA participates in monthly conference calls with DBHDD staff and their Regional Coordinators. During these calls information regarding HUD 811 vacancies is reiterated, and any questions the Regional Coordinators may have about specific properties or processes are answered.
• On April 9, 2018 DCA conducted a webinar covering the RPH program and providing information on how they can become RPH approved housing providers targeted individuals leaving a state prison with a mental health illness. The presentation was made available to all DBHDD Community Service Board (CSB) executives. 20 CSB executives attended the webinar. Several CSBs attended subsequent RPH application workshops. The RPH program has a bi-annual application process for potential housing providers, and the spring cycle will close on May 30, 2018.
• Many DBHDD providers, such as CSBs and agencies with PATH teams, also receive HUD funding for housing through DCA. Many DBHDD providers are currently recipients of ESG and S+C funding in particular. These HUD funded housing grants are awarded on an annual basis. In March 2018, DCA conducted four ESG/HOPWA/S+C Supportive Services application workshops throughout the state (Macon, Moultrie, Chamblee, Augusta), in addition to one webinar. In April 2018, three follow-up Q&A webinars were conducted related to the ESG/HOPWA/S+C Supportive Services applications. DBHDD providers were invited to attend all of these workshops and sessions and were encouraged to apply for funding.
• The Re-entry Housing Program has conducted workshops related to its spring funding cycle in April 2018. In addition to a webinar, three in-person application workshops were held, in conjunction with the Department of Community Supervision (DCS), in Macon, Augusta, and Gainesville. At least several DBHDD providers attended these workshops, and many others were notified and encouraged to apply.
• DCA has agreed to waive the normal one year waiting period for HCV preference vouchers that are ported to PHAs that may be more appropriate geographical locations for eligible individuals or families. Anyone who is eligible for an HCV preference voucher due to Settlement eligibility is immediately able to port to another PHA without waiting.
• The Atlanta Housing Authority (AHA) has agreed to convert GHVP vouchers for individuals whose leases are expiring under that program to HCV vouchers. This transition is made entirely within the AHA's jurisdiction, outside of DCA's Settlement eligible preference, and is an example of how DCA has been able to work with another PHA to expand HCV opportunities to the Settlement eligible population.
• DCA has conducted a 6-month series (2019) of Supported Housing workshops including Access to Federal Housing Programs, Fair Housing, Reasonable Accommodation, Landlord/Tenant Law, Olmstead, Quality Housing Inspections.

DBHDD provides transition planning from the day of admission. Significant policy revision and training have occurred to promote improved hospital to community transition. An individual's own recovery goals are considered when developing the plan of care and assisting with the linkage to community-based services after transition into the community. Once a community service provider is identified, and a release of information from the individual, providers are strongly encouraged to actively engage in the transitioning and discharge planning process. The hospital is recovery focused and utilizes the "Individualized Recovery Plan" to guide an individual's treatment and recovery.

Individuals who have taken longer to stabilize (more than 45 days) or who have been readmitted within 30 days of discharge or 3 times in 12 months receive an additional level of transition planning in order to support the individuals' successful transition into the community. DBHDD is able to offer those transitioning from hospitals into community settings a continuum of housing options based on need. Housing options range from supervised residential settings to supported independent apartments based on housing first principals.

Our Assertive Community Treatment (ACT) teams provide services and supports to approximately 1500 persons annually, who have a serious and persistent mental illness categorization. ACT along with CST which support on average 350 persons annually who

have a serious and persistent mental illness categorization maintain a housed/non-homeless average percentage of 95% for persons enrolled in these services. DBHDDs contracted providers of Supported Employment assist 2000 persons in exploring vocational opportunities and obtaining jobs and maintain a competitive employment rate for enrolled individuals of 49%.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

   b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

   a) Child welfare? (●) Yes ( ) No

   b) Juvenile justice? (●) Yes ( ) No

   c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

   a) Service utilization? (●) Yes ( ) No

   b) Costs? (●) Yes ( ) No

   c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

   b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

   a) to the adult M/SUD system? (●) Yes ( ) No

   b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   System of Care (SOC) is an organizational framework for how behavioral health services and supports delivery systems can work together to fit the needs of the community, county, region, or state. The SOC framework is based on core principles and values: community based, child-centered and family focused (involving youth and family as partners), culturally and linguistically competent, comprehensive, individualized, and provided in the least restrictive, most integrated and most appropriate setting as possible.

   Starting in 1984, Georgia began utilizing several SAMHSA and CMS grant initiatives to build a strong, statewide SOC: Child and Adolescent Service System Program recipient; Child and Adolescent State Infrastructure; Substance Abuse Coordination; Healthy Transitions Initiative; CMS Alternatives to Psychiatric Residential Treatment Waiver Demonstration Grant; CHIPRA Quality Improvement; Project LAUNCH; Project AWARE; and the Cooperative Agreement for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (SEDs) Grant (Systems of Care Expansion Grant).

   Georgia's system is designed with local, regional, and state-level SOC infrastructures that complement and support each other. Local Interagency Planning Teams (LIPTs), required by Georgia Code § 49-5-225, were established at the local level to improve and coordinate services for children and youth with SEDs. The main charge of LIPTs are to bring planning and resources to support

youth with remaining in their communities, homes, and schools. There are 119 LIPTs covering all 159 counties located across the state that meet as needed to coordinate services and supports for youth and families. Systemic issues identified by LIPTs are passed along to the Interagency Directors Team (IDT).

Per Georgia Code § 37-2-4, Georgia's Behavioral Health Coordinating Council (BHCC) was created in 2010 to "identify overlapping services regarding funding and policy issues in the behavioral health system." The BHCC is a commissioner-level council that supports behavioral health services throughout the state. The BHCC is chaired by the Department of Behavioral Health & Developmental Disabilities (DBHDD) Commissioner, and members include commissioner and division director-level representatives from each state agency that is impacted by behavioral health, as well as members of the Georgia legislature, and family and consumer representatives. The BHCC meets quarterly, and the chair provides regular updates to the Governor.

In 2011, DBHDD formalized the IDT as a working group of the BHCC. The IDT is the state's multiagency SOC leadership collaborative, whose mission is to manage, design, facilitate, and implement the SOC in Georgia. The IDT meets monthly. Membership, which is composed of director-level representatives from all child-serving agencies in Georgia and other partner organizations. Agency membership includes: Behavioral Health & Developmental Disabilities; Community Health (Medicaid Authority); Early Care & Learning; Education; Family & Children Services; Juvenile Justice; Public Health; and Vocational Rehabilitation Agency. Remaining members include: Care Management Entities (Lookout Mountain CME, View Point Health CME); The Carter Center; Children's Healthcare of Atlanta; Georgia Appleseed; Georgia Early Education Alliance for Ready Students; Georgia Parent Support Network; Georgia State University (Center of Excellence for Children's Behavioral Health; Center for Leadership in Disability); managed care organizations (Amerigroup; CareSource; PeachState; WellCare); Mental Health America of Georgia; National Alliance on Mental Illness; Resilient Georgia; professional associations (Georgia Alliance of Therapeutic Services for Children & Families; Georgia Association of Community Service Boards; Georgia Chapter, American Academy of Pediatrics; Together Georgia; United Way of Greater Atlanta; and Voices for Georgia's Children. The Centers for Disease Control and Prevention is a consulting partner.

7. Does the state have any activities related to this section that you would like to highlight?

Georgia has utilized several SAMHSA and CMS grant initiatives to build a strong, statewide SOC. Further, Georgia has sustained programs, supports, and momentum with state funds after our SAMHSA grant periods have ended. For example, the Center of Excellence for Children's Behavioral Health (COE) was created in partnership with Department of Behavioral Health & Developmental Disabilities (DBHDD). Modeled after the Institute for Innovation at the University of Maryland, a national leader in children's behavioral health services, the COE is housed in the Georgia Health Policy Center, in the Andrew Young School of Policy Studies at Georgia State University. Initially the COE was created to provide technical assistance, monitor, and evaluate, High Fidelity Wraparound (HFW) supporting children with Severe Emotional Disorders, and for the first three years, was funded with federal funds saved through the PRTF demonstration grant. Realizing the value of the COE, DBHDD has sustained the center with state dollars and the responsibilities of the COE have continued to grow. The COE provides support in a number of ways, most notably through training and technical assistance, fidelity monitoring, research and evaluation, and policy and finance publications. Additionally, the COE provides backbone support for the Interagency Directors Team, and for the Georgia System of Care.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

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19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

   DBHDD continues to implement a multifaceted approach to reduce incidence of suicide in Georgia. Among these efforts, is the application of the Zero Suicide approach supported by DBHDD Policy 01-118, Suicide Prevention, Screening, Brief Intervention and Monitoring. The Zero Suicide framework is a system-wide, organizational commitment to safer suicide care in health and behavioral health care systems – Georgia has been working with experts to apply this framework to college and university campuses. The framework is based on the realization that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted health care system. A systematic approach to quality improvement in these settings is both available and necessary. To date, there have been three Zero Suicide Academies completed and more than two dozen college and university personnel trained in this approach.

   This policy can be found at this link: https://gadbhdd.policystat.com/policy/5998394/latest/

   Additionally, the Georgia DBHDD has implemented evidence-based suicide screening, assessment, and safety planning trainings for clinicians with responsibility for suicide screening and care.

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? ◉ Yes ○ No

   If so, please describe the population targeted.

   First, the Georgia DBHDD has implemented a statewide training initiative to support clinicians and suicide gatekeepers. It's called the Mental Health Awareness Training (MHAT) Project. The goal of the Mental Health Awareness Training (MHAT) Project is to help Georgia communities to reduce risks that may contribute to suicide attempts and/or death by suicide.

   Objectives include the following:
   1. Provide at least 20 evidence-based mental health awareness trainings across the state annually, targeting counties in DBHDD regions 1, 2, 3, 5, and 6 that were identified in 2015 as having the highest rates of suicide deaths in Georgia.
   2. Refer at-risk and vulnerable populations to participating community service boards (DBHDD's safety-net providers).
   3. Train at least 600 individuals (average 200 per year) by the end of the three-year project in evidence-based trainings, such as Question-Persuade-Refer, adult and youth Mental Health First Aid, Assessing and Monitoring Suicide Risk, Applied Suicide Intervention Skills Training, and SuicideTALK. This objective includes training 50 trainers to help sustain mental health awareness training capacity after the grant ends.

   Individuals targeted for MHAT will include those who can provide support to veterans, youth, and older adults. Training participants will include behavioral health professionals, nurses, teachers, clergymen, community suicide prevention coalition members, caregivers, corrections staff, first responders, youth workers, school support staff, and veterans and family members of armed service members.
   Overall, Georgia DBHDD focuses its efforts on people at risk of suicide, serious mental illness (SMI), and geographically – communities with high burdens of suicide deaths.

   Garrett Lee Smith (GLS) Georgia Suicide Safer Communities for Youth Project
   As a part of larger funding issued to The Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD)

through the Garrett Lee Smith federal funding from September 2015 through September 2020, The College and University Coalition, made up of over 30 institutions of higher education including technical schools and public and private colleges and universities, is included in the Georgia Suicide Safer Communities for Youth Project.

Under this project, The Georgia College and University Suicide Prevention Coalition will provide a yearly Suicide Prevention Conference for Colleges and Universities, three additional suicide prevention training opportunities a year and assessment, data collection, tracking and evaluation services for the College Coalition. The Georgia College Suicide Prevention Coalition (College Coalition) will oversee targeted college and post-secondary education efforts. The efforts of Georgia's colleges and universities are included in the GLS goals to serve 5,000 youth and their families over the life of the 5-year project.

Strategic Prevention Framework (SPF) for Suicide Prevention
The Georgia Department of Behavioral Health and Developmental Disabilities, Office of Behavioral Health Prevention has demonstrated success as a leading authority on combating suicide risk through its statewide, regional, and local partnerships. Further, the success of its Garrett Lee Smith youth suicide federal grant continues to build prevention capacity for youth service providers, colleges/universities, etc.

Georgia's suicide rates have typically been under the national average over the last 10 years, while the South's rates are over the national average. In 2016, suicide deaths and rates were highest for ages 50-54, followed by ages 20-24. In the 80-84 age group, the suicide rate peaks, but the number of deaths is not as high in older age. While there is no one single cause for a death by suicide, there are opportunities using evidence-based approaches to greatly reduce suicide risk-taking for youth, adults, and vulnerable populations which DBHDD is uniquely qualified to lead in Georgia.

The overall focus on prevention is done through a widely accepted, evidence-based Strategic Prevention Framework (SPF) that has been successfully used in Georgia substance abuse prevention programs. The five steps include: 1. Assessment, 2. Capacity, 3. Planning, 4. Implementation and 5. Evaluation as part of an intensive capacity-building approach to addressing a set of data driven priorities at the community level. Communities will be selected through a separate process to participate in the Strategic Prevention Framework for Suicide Prevention. SPF Suicide Prevention communities will be in selected high burden counties in Georgia based on 1) death by suicide rates county data; 2) And an existing capacity to address suicide in context of Opioids and substance addiction.

In February 2019, the Georgia DBHDD updated and expanded DBHDD Policy 01-118 Suicide Prevention, Screening, Brief Intervention, and Monitoring. DBHDD has specifically targeted consumers at-risk for suicide in its Tier 1 and Tier 2 and 2+ provider organizations. The revised policy provides standards for evidence-based suicide screening clinical trainings, system-wide screening protocols, and a companion document to support clinical responses.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

1. The state of Georgia has not updated the suicide prevention plan in the last two years. Georgia has taken initial steps to update the existing plan by convening a diverse, cross-section of suicide prevention and mental health stakeholders for a consultation meeting in March 2019. The consultation meeting resulted in several committees being formed to prioritize suicide prevention goals. Suicide prevention goals and objectives are being drafted for review by December 2019. The final version of the 2020-2025 plan is expected to be finalized by spring 2020.

3. After researching successful approaches to suicide reduction, the Georgia DBHDD under its Garrett Lee Smith Youth Suicide Project has identified seven essential elements of suicide care for college and university systems to adopt:
(1) Lead system-wide culture change committed to reducing suicides
(2) Train a competent, confident, and caring workforce
(3) Identify individuals with suicide risk via comprehensive screening and assessment
(4) Engage all individuals at-risk of suicide using a suicide care management plan
(5) Treat suicidal thoughts and behaviors using evidence-based treatments
(6) Transition individuals through care with warm hand-offs and supportive contacts
(7) Improve policies and procedures through continuous quality improvement

4. The Zero Suicide Academy is one specific initiative to focus on improving care transitions for suicidal individuals known to college personnel, returning after care from local clinics and hospitals.
Additionally, GA DBHDD has provided specific training and protocol development support for social workers and medical providers at Children's Hospital of Atlanta (CHOA), and Grady Memorial Hospital in Atlanta in beginning in 2019.

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

   If yes, with whom?

   Center for START Services
   RI International
   Georgia Public Safety Training Center
   City of Atlanta Continuum of Care
   University of Georgia School of Social Work
   Children's Healthcare of Atlanta
   Georgia Appleseed
   DeKalb Criminal Justice Treatment Coalition

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

   DBHDD has developed partnerships with agencies that serve and support people with addictive diseases, adults with Serious and Persistent Mental Illness, and Children and Adolescents with Serious Emotional Disturbances and their families. These agencies include the Department of Community Health, Division of Medicaid Assistance; the Department of Corrections; the Department of Community Supervision, Department of Public Health; the Georgia Vocational Rehabilitation Agency; the Department of Community Affairs, Housing Division; the Department of Education; the Department of Public Health; the Department of Human Services, Division of Aging Services DBHDD leads or participates in Councils with multiple agency representatives that address the needs of our target population to include the DBHDD Behavioral Health Coordinating Council, Georgia Interagency Council on

Homelessness, and the State Behavioral Health Planning and Advisory Council, the Fulton County Justice and Mental Health Task Force, Metro Atlanta Reentry Coalition, Council of Accountability Court Judges, Criminal Justice Coordinating Council, Macon Public Offenders Office and Sheriffs Council. In addition, Behavioral Health staff serve on advisory and governing bodies. Through these advisory and governing bodies, DBHDD coordinates and collaborates to plan for and implement services and supports needed by behavioral health consumers. In addition, DBHDD has developed agreements with other state agencies to either provide or collaborate on obtaining needed services and supports. The State Behavioral Health Planning and Advisory Council (BHPAC) includes representatives from various state agencies.

In 2011, DBHDD formalized the Interagency Director's Team (IDT) as a working group of the Behavioral Health Coordinating Council (BHCC). The IDT is the state's multiagency SOC leadership collaborative, whose mission is to manage, design, facilitate, and implement the SOC in Georgia. The IDT continues to meet monthly. Membership is composed of director-level representatives from all child-serving agencies in Georgia and other partner organizations. Agency membership includes: Behavioral Health & Developmental Disabilities; Community Health (Medicaid Authority); Early Care & Learning; Education; Family & Children Services; Juvenile Justice; Public Health; and Vocational Rehabilitation Agency. Remaining members include: Care Management Entities (Lookout Mountain CME, View Point Health CME); The Carter Center; Children's Healthcare of Atlanta; Georgia Appleseed; Georgia Early Education Alliance for Ready Students; Georgia Parent Support Network; Georgia State University (Center of Excellence for Children's Behavioral Health; Center for Leadership in Disability); managed care organizations (Amerigroup; CareSource; PeachState; WellCare); Mental Health America of Georgia; National Alliance on Mental Illness; Resilient Georgia; professional associations (Georgia Alliance of Therapeutic Services for Children & Families; Georgia Association of Community Service Boards; Georgia Chapter, American Academy of Pediatrics; Together Georgia); United Way of Greater Atlanta; and Voices for Georgia's Children. The Centers for Disease Control and Prevention is a consulting partner.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   Planning for Behavioral Health services, including substance abuse treatment services, services, begins at the local level, initiated by the Field Offices in the six regions of DBHDD. Each Field Office works with their providers and key stakeholders to identify needs in their region. A primary mechanism for this is through Regional Community Collaboratives. In addition, there are Regional Advisory Councils (RACs) which include consumers and family members that provide recommendations to the regions and DBHDD. The Chairs of these RACS form a State Leadership Council and this Council has membership on the GBHPAC. The process incorporates input from individuals receiving services, families, advocates, community and hospital providers, and other local stakeholders. The process informs the delivery of behavioral health services in Georgia. The Field Office process is guided by the consumer-oriented, community-based values and principles of DBHDD. Field Offices:

   • Actively seek input from local stakeholders through public forums, written surveys, public comment at meetings, and individual input from consumers and families;
   • Ensure regional priorities, based on the local needs of consumers, families, advocates, providers and other stakeholders, are communicated;
   • Ensure the consideration of prevalence data and population demographics;
   • Inform local stakeholders of the regional priorities and needs;
   • Ensure the development of priorities focused on the entire regional system of care including community programs and state hospitals;
   • Provide input for the development of overall state plans for services; and
   • Inform the Department's annual budgetary process.

   At the state level, DBHDD's Substance Abuse Behavioral Health Plan is posted on the departmental website for review and comment and the plan is sent to the BHPAC for review. A few years ago, the Council voted to expand the role of the Council to a BHPAC and held meetings with the Director of the DBHDD Office of Addictive Diseases to discuss roles and functions of the Council related to the SABG and the overall planning and delivery of substance abuse services. The Council continues to work on further development of the BHPAC related to substance abuse representation. The leadership from the Addictive Disease Office regularly attends Council meetings and provides reports on delivery of substance abuse and prevention services in Georgia. In addition, there have been representatives from the Substance Abuse provider and advocacy community added to the Council as well as family members of persons with co-occurring disorders. The Council continues to focus on expansion of its substance membership representation and to educate

Council members of the needs of consumers with substance abuse and co-occurring treatment needs.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Georgia BHPAC has been in existence for many years since there was a federal mandate to have a Council. The Council meets every other month and has ad hoc meetings as needed to conduct Council business. The Council Program Committee sets the agenda for each meeting which always includes an opening from a graduate of the RESPECT Institute. Graduates of this institute share their stories which help to inform Council members of the challenges and needs as well as successes of the individuals. Meetings also include opportunities for members to share concerns as well as educational information. There are also reports from DBHDD staff leadership from the Offices of Adult Mental Health; Children, Young Adults and Families; Recovery Transformation, Federal Grants and Cultural and Linguistic Competency; Deaf Services; and Addictive Diseases. In addition, the Council plans for presentations by service providers and site visits to stay abreast of new service delivery activities and programs. GBHPAC agendas and minutes from SFY19 are attached.

The Council has made a concerted effort to develop communication technology to keep the broader community and Council members aware of Council activities. To this end, a Council website has been developed as well as other use of social media. The Council has become more visible and is able to share information more broadly.

The Council By-Laws were updated in 2016 and 2018 to reflect the changes made to the GBHPAC. The amended 2018 By-Laws are attached. The duties and responsibilities of the Council are included in a recently revised new member orientation handbook. Council members actively support and participate in Mental Health Day at the Capitol, Substance Abuse Day at the Capitol, Suicide Prevention Day at the Capitol as well as Children's Mental Health Day. Also, during the legislative session and throughout the year Council members stay abreast of current issues and legislation, and advocate for the needs of adults with SMI and SUD, as well as children and adolescents with SED. There are regular reports at the Council meetings on state and national legislative issues pertaining to the target populations. Many Council members are also active members of their local Regional Advisory Councils (RACs) and some are members of the Leadership Council of the RACs.

The council reviews the Comprehensive Mental Health State Plan, the Substance Abuse Block Grant Plan and submits recommendations for modifications to the state. The Council serves as an advocate for people in recovery from mental health diagnoses, children and youth with serious emotional disturbances and other individuals with behavioral health challenges; and monitors, reviews and evaluates a plan for allocation and adequacy of behavioral health services within the state, makes recommendations for service improvements, and reviews the implementation reports for the mental health block grant and substance abuse block grant.

The Council has been involved in the development of the MHBG application by participating in meetings to review the priority areas, goals and indicators for this submission of the MHBG. Both the Child and Adolescent and Adult Mental Health committees held meetings to complete the review process and present their findings to the GBHPAC as a whole. A letter from the Council Chair is attached indicating the Council's participation in the MHBG application development process. In addition, agendas and minutes of meetings held in FY19 and the revised By-Laws are attached. The GBHPAC is also sent the draft of the goals and indicators for the SABG and have opportunity to disseminate, review and comment.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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Footnotes:

On behalf of the GBHPAC, DBHDD applied for and was selected for the 2018 State TA Leadership Academy offered by SAMHSA through the Advocates for Human Potential. In February, the BHPAC Executive Committee began participating in virtual learning community group meetings with other awardees. The Executive Committee of the GBHPAC and DBHDD MHBG State Planner participated in all state cohort calls, monthly state coaching calls and received two site visits from the Advocates for Human Potential. The purpose of the academy was to help state planning council teams build essential leadership skills among chairs, co-chairs, vice-chairs and other Council leaders. Topics included: Foundations for the Leadership Academy; Leadership with Vision; Decentralized Leadership; Collaborators and Catalysts; Culture and Diversity; Meeting Management; Future Leaders and Mentoring; and, Sustaining the Vision. The GBHPAC presented a summary of its project plan on an all state call in August 2018 and continues to make progress on completing the project plan.

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

246 Sycamore Street, Suite 260 **Decatur, Georgia 30030**
Phone: 404.687.9487 Fax: 404.687.0772 gbhpac@gmhcn.org

August 24, 2018

Judy Fitzgerald
GBHDD Commissioner
2 Peachtree Street, N.W., 24th Floor
Atlanta, Georgia 30303

Dear Commissioner Fitzgerald:

The Georgia Behavioral Health Planning and Advisory Council (GBHPAC) has participated in the development of the priorities and indicators for the 2019-2020 plan as well as reviewed the application of this year's Mental Health Block Grant Program Plan. Our Georgia Department of Behavioral Health and Developmental Disabilities (GDBHDD) has kept us abreast of changes and updates with regard to writing the plan. Also, GDBHDD's sister agencies (see the list of involved state agencies) who are a part of our Council, have made every effort to assist GDBHDD in this time of ongoing change and improvement for Georgia's behavioral health system and its commitment to infuse recovery in all aspects of the delivery of services.

This continues to be a time of transition in the delivery of behavioral health services in the State of Georgia. As you know, our GBHPAC Committees have worked very closely this year in developing program and support for adults, children, young adults, and families. Our work this past year in developing a stronger Council and new leadership for the future has been impressive and given new energy to Council members to partner with the State in the direction and implementation of a plan.

The State has created new programs, expanded peer supports, housing, and collaborated with the Georgia Vocational Rehabilitation Agency to enhance supported employment services. There still are challenges ahead for child and adolescent services and the council is looking forward to future plans; The GBHPAC supports a greater focus on children and youth services and supports.

A few years ago, our Planning and Advisory Council conducted a survey of providers statewide, asking them if public mental health services were serving Georgia's children well. Our report, titled *Failing the Children*, revealed that it was not. One provider told us, "The more children I serve, the more money I lose." In a number of our public mental health agencies the cadre of children and adolescent providers had gone from 100+ to less than 5

Children and families were often unable to get the help they needed, with extremely negative life outcomes. A gradual rebuilding began to occur, then a Federal lawsuit in 2010 forced funds into the adult crisis system. That legal action is now completed and there is a strong will to do some serious rebuilding of services for what we now call Children, Young Adults and Families. DBHDD has redirected some funds to support school-based Mental Health, in Project APEX.

Our Behavioral Health Regional Advisory Councils statewide have just identified their top 3 priorities for 2019. Improved behavioral health services for children and their families is at the top of their list. Our State plan 2019 - 2020 adds volume to the call for serious investment and improvement.

The really good news is GDBHDD continues to move forward at a rapid pace.
GDBHDD's rapid pace includes behavioral health's Community Behavioral Health Core Provider Initiative, and in the most innovative of transformations, the designation of an Administrative Service Organization (ASO) to centralize and consolidate behavioral health services throughout the state. The ASO will also facilitate the GDBHDD to effectively monitor services in 'real time' to provide easy access to high quality health care as is the mission statement and mission of the GDBHDD.

The Georgia Behavioral Health Planning and Advisory Council is so grateful for your continued support and leadership. We remain a committed partner with GDBHDD to ensure that all Georgians who need services get what they want and need, to recover and maintain their wellness. The council will continue to advocate for people with behavioral health concerns regardless of age, race, ethnicity, gender or religious preference.

Sincerely,

Sandra Mullins

Sandra A. Mullins

Chairperson

BY LAWS OF THE

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

ARTICLE I: AUTHORITY

The Georgia Mental Health Planning and Advisory Council was established in 1989 according to the Public Health Services Act, Title XIX, Section 1914 (b) resulting from Public Law 106-310 by the Division of Mental Health, Developmental Disabilities and Addictive Diseases within DHR established in OCGA Chapter 37-2. The Georgia Behavioral Health Planning and Advisory Council continues in this capacity under the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) established in OCGA Chapter 37-1 in 2009.

ARTICLE II: PURPOSE

The purpose of this council is to review the Comprehensive Mental Health State Plan, the Substance Abuse Block Grant Plan and to submit recommendations for the modifications to the State: to serve as advocate for people in recovery from mental health diagnoses, children and youth with serious emotional disturbances and other individuals with behavioral health challenges; and to monitor, review and evaluate, not less than once each year, a plan for the allocation and adequacy of behavioral health services within the state, make recommendations for service improvement, and review implementation reports for Mental Health Block Grant and Substance Abuse Block Grant.

ARTICLE III: SCOPE OF COUNCIL ACTIVITIES

1. The scope of this council shall encompass the review of the Mental Health Block Grant and submit to the State any recommendations for modifications to the plan. The Council may utilize whatever information and assistance that is available within the DBHDD and other agency partners to effect change following such examination and advocacy.

2. Monitor, review and evaluate the allocation and adequacy of Mental Health Services.

3. Advocate on behalf of people in need of Behavioral Health Services driving toward the goal of recovery.

ARTICLE IV: MEMBERSHIP

A. The Council will be composed of residents of the state including representatives of state agencies with respect to mental health, education, vocational rehabilitation, criminal justice, juvenile justice, housing, social services, medicaid, aging services, and addictive disease.

B. PHS Act, Title XIX, Part B, Section 1914 (b) further specifies that not less than 50 percent of the members of the Council will be individuals who are not State employees or providers of mental health services:

Updated 05/7/18

1. The Commissioner of DBHDD, DBHDD Director of Community Relations and DBHDD Director of the Office of Recovery Transformation.

2. One organizational membership for the Georgia Mental Health Consumer Network, Mental Health America of Georgia, National Alliance on Mental Illness - Georgia, Georgia Parent Support Network, Georgia Council on Substance Abuse, and Georgia Advocacy Office.

3. Two at-large representatives, who are adults in recovery from serious and persistent mental illness, and two at-large representatives, who are adults in recovery from addictive disease challenges, nominated by the membership committee and confirmed by the Council.

4. Two at-large Children and Youth (C & Y) family member representatives; caring for a C & Y living with mental health and/or addictive disease challenges; one family representative for C & Y living with a mental health diagnoses and one family representative of C & Y living with addictive disease challenges. There will be two at-large C & Y representatives; one in recovery from mental health diagnoses and one in recovery from addictive disease challenges. They will be nominated by the Membership Committee and confirmed by the Council.

5. Chair of DBHDD Statewide Leadership Council.

6. Council membership will include a significant number of people who are Adults, Children, Youth, and Family Members that have lived experience with behavioral health diagnoses.

C. Council membership shall consist of; general representation from public agencies and private entities, concerned with the needs, planning, operation, funding and use of behavioral health services and related supported services.

D. The Council shall consist of not less than 24 members. Members can be appointed for a total of two (2) consecutive terms. At the end of the first three-year-term, the Membership Committee may ask the council member if they are willing to serve a second three-year-term. If the council member agrees, the Membership Committee will report to the Council Chair, who will announce their acceptance of a second term. If the council member does not wish to serve a second term, the Membership Committee will conduct a search for nominees to submit to the Council for recommendation. After one year off the Council, a former member can be reappointed for up to two (2) consecutive terms. State employees who represent agencies on the Council are exempt from term limits. They will serve until the fail to meet the Council attendance policies and/or a different representative is appointed by the agency they represent. Each year, at the first meeting held after September 30, or when there is a vacancy, the Membership Committee will present nominations as prescribed above. After confirmation by the Council, the proposed list of new members will be sent to the Commissioner of the DBHDD with a recommendation for appointment. Members whose terms expire will be removed from the council's membership list when the Commissioner appoints the new slate of members. Members representing state agencies who withdraw will notify their agency director and request that she/he notify the council chairperson of the reappointment. Each member shall keep confidential all sensitive

information pertaining to council members and applicants, both during and after serving on the council.

E. Vacancies shall be filled by council recommendations to the Commissioner of the DBHDD for appointment to fill periodically occurring vacancies. The Council will annually review the agencies represented on the council and make needed additions/deletions.

F. The council members shall serve without compensation but shall be reimbursed for any and all actual necessary expenses incurred in connection with the performance of duties authorized by the council. After a nomination is approved by the council and sent to the Commissioner for official appointment, the nominee is entitled to expense reimbursement.

G. In order to ensure that the Council is representing everyone, member attendance at all council meetings is expected. Understanding that conflicts will exist, the council will accept occasional absences. Sign in sheets for attendance will be confirmed by the secretary. The Council has developed the following guidelines.

MEMBERSHIP ATTENDANCE SHALL CONSIST OF:

1. Attendance at all scheduled meetings every year. If a member is absent for two (2) consecutive meetings, a letter notifying the member of his/her potential removal will be generated. If the member is a state employee, a letter to his/her Commissioner will be generated. If a member is absent for more than two (2) of any six (6) meetings in a calendar year he or she will be referred to the Executive Committee (EC) for follow up and recommendations. The (EC) shall take into account any and all events beyond the members control such as illness or hardships prior to making a recommendation. If the recommendation is removal, then the case is submitted to the membership committee for search of a replacement. Absent is defined as not being present and not represented by a permanent alternate. In order to vote on an issue, the council member or permanent alternate must have been in attendance, as defined above, for the discussion of the issue.

2. If a council meeting date is changed with less than 20 day notice to members, an absence at that meeting will not be recorded as an absence.

3. If a member fails to meet obligations of membership, as detailed above or as determined by the Executive Committee (EC) after being referred for review, the Membership Committee shall request council recommendations to be vetted and to submit to the Commissioner of DBHDD to appoint a replacement for the member.

H. The Council is consciously and proactively inclusive of all areas of diversity including, but not limited to, age, race, ethnicity, creed, color, sex, gender identity, sexual orientation, marital status, religion, spirituality, disability, national origin, military/veterans status, or behavioral health issues.

Updated 05/7/18

I. Each member shall designate a permanent alternate to attend council meetings in the membership place in the event of the members absence and to vote the member's proxy if necessary. Permanent alternates may attend council meetings with their member but may not vote if the member is present at the meeting. Designation of permanent alternate by a member shall be made in writing to the Council Chairperson Staff.

J. Visitors may attend council and committee meetings, visitors do not have voting privilege.

ARTICLE V: QUOROM

One-third of the Council's voting members shall constitute a quorum. The action of a majority of a quorum present at the time of voting shall constitute the action of the Council. All members or permanent alternates attending in the place of members are entitled to vote. The Chair has no vote unless there is a tie.

ARTICLE VI: OFFICERS

A. The Chairperson shall be the principle officer of the GBHPAC. The Chairperson shall preside over all the meetings as needed, appoint committees and generally supervise and direct all actions of the Council with assistance of the Council and staff from DBHDD. The Chairperson shall be elected by the council membership and shall hold office for three years and as necessary appoint members to officer vacancies to complete a term.

B. There shall be a Chair Elect whose term runs concurrent to the Chairperson. The Chair Elect shall represent the Chair during his/her absence at council meetings or other events when the Chairperson would have represented the Council. The Chair Elect will take over as Chair when the Chairperson's term expires or the Chairperson leaves the Council for other reasons.

C. At the September meeting prior to the Chair Elect assuming the Chairperson's role, a new Chair Elect will be elected by the membership. The nominating committee will present a slate of qualified nominees for this position and any other positions whose term is scheduled to end. The Chair Elect must be someone who has been a member a minimum of one year. Terms can be extended to allow for services as an elected officer of the Council. The Chair's term of office can be extended to allow for a term as past chair.

D. There shall be two Vice-Chairpersons elected by the Council each to serve three year terms. One Vice- Chairperson shall be elected to represent children and young adults with behavioral health issues and their families. One Vice- Chairperson shall be elected to represent adults with behavioral health issues. These Vice-Chairpersons shall hold an annual meeting with the Child and Adolescents Committee and the Adult Behavioral Health Committee in coordination with the designated DBHDD representative to review the State's Annual Plan for mental health services and report back to the full Council any recommendations and/or comments. The two Vice-Chairpersons terms may be staggered to avoid a full range of leadership in the same year.

Updated 05/7/18

E. A Secretary shall be elected by the Council for a three- year term to oversee recording and distribution of minutes of meetings and written announcements of all meetings. The secretary shall perform other such duties as the chairperson directs and shall utilize assistance by the council's administrative assistant.

ARTICLE VII: ADMINISTRATIVE ASSISTANT

A. An Administrative Assistant shall be retained by the Council. The Administrative Assistant shall administer the needs of the Council and as the Chairperson directs. Under the direction of the Secretary, the Administrative Assistant will record the meeting minutes and distribute the minutes of the meetings and written announcements of all meetings.

B. The Administrative Assistant will give assistance to the staff liaisons of the DBHDD with all information about council business and assist with the Mental Health Services Block Grant issues that affect the Council and any other duties as instructed by the Council Chairperson.

ARTICLE VIII: MEETINGS

A. The GBHPAC shall meet a minimum of four times a year. Members shall be notified in writing of the date, time and place of the meeting at least twenty days (20) in advance.

B. Special meetings of the Council may be called by the Chairperson as necessary to fulfill the purpose of the Council.

ARTICLE IX: COMMITTEES

A. The GBHPAC shall have an Executive Committee to include at a minimum the Chairperson, the Chair-elect, two Vice-chairpersons and the Secretary. Additional members of the Executive Committee may include chairpersons of standing committees and past-chair. The Executive Committee shall be responsible for the formulation of the meeting agenda for the full Council and for the conduct of such Council business as may arise and require attention at times other than during regular meetings of the full Council.

B. Standing committees are: Adult Behavioral Health, Children, Young Adults and Families, Planning Committee, Advocacy Committee, Nominating and Membership Committee.

C. The GBHPAC shall have such standing and ad hoc committees as the council shall deem necessary for the proper conduct of its business. Such committees shall be appointed by the Chairperson and shall report directly to the council.

D. The Council shall have the power to abolish or create committees by two-thirds vote of the members present. Persons who are not members of the Council may serve on committees.

ARTICLE X: AMENDMENTS

Updated 05/7/18

These by-laws may be amended by a majority vote of a quorum at any meeting of the GBHPAC, provided that the proposed amendment shall have been submitted in writing to the by-laws committee at least 30 days prior to such meeting.

Updated 05/7/18

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

The Carter Center
453 Freedom Parkway
Atlanta GA, 30307
July 10, 2018
AGENDA

10:00 a.m.	**Welcome and Introductions – Sandra Mullins, Chair** Moment of Silence Respect Institute Graduate – Michelle Boatright
10:30 a.m.	**Sharon Jenkins Tucker introduction of Facilitators – Ted Johnson & John Hudgens**
10:35 a.m.	**How to strengthen Council leadership?**
11:45 a.m.	**How to strengthen Council engagement?**
12:15 p.m.	**Lunch**
1:00 p.m.	**How to enhance the relevance and visibility of the Council?**
2:00 p.m.	**How to strengthen the role of the Council with the State BH agency?**
3:00 p.m.	**Summarizing the day's questions and discussions**
4:00 p.m.	**Adjourn for the day**

July 11, 2018

10:00 a.m.	**Welcome and introductions – Sandra Mullins, Chair** **Moment of Silence**
10:10 a.m.	**How to strengthen Council agenda and meeting quality?**
11:10 a.m.	**How to strengthen committees?**
12:15 p.m.	**Lunch**
1:00 p.m.	**Review: How to use information from the two days to create an action plan**
3:00 p.m.	**Adjourn**

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

The Carter Center
453 Freedom Parkway
Atlanta, GA 30307
July 10-11, 2018
10:00am – 4:00pm
Meeting Minutes

Members Present: Linda McCall, Sandra Mullins, Felicia Hardy (for Yvette Sangster), Jean Toole, Sue Smith, Pierluigi Mancini, Bertrand Brown, Sharon DeMille, Jean Olshefsky, Rebecca Blanton, Jewell Gooding, John Shereikis, Faye Taylor, Sherry Jenkins Tucker, Prince Moorman(for Cassandra Price), Lucy Hall, Erika Johnson, Ron Koon, Amy Kuhns, Cynthia Wainscott, Neil Campbell, Mary Shuman (for Tony Sanchez), Thom Synder

Department Staff: Dawne Morgan, Jill Mays (for Terri Timberlake), Danté McKay

Guest: Anthony Williams, Michelle Boatright, Colleen Mousinho, Harvinder Makkar, Ted Johnson, John Hudgens

Introductions, Moment of Silence

The Chair, Sandra Mullins called the meeting to order and commenced with introductions followed by a moment of silence.

Respect Institute Graduate: Michelle Boatright

Michelle Boatright is a Respect Institute graduate and shared her recovery story entitled redeemed. The Respect Institute empowers those in recovery to share their recovery journeys, educating people about people with mental illness and helping to eliminate stigma.

The Respect Institute works in collaboration with multiple agencies and organizations such as GDBHDD, GMHCN, and MHA of Georgia.

Sharon Jenkins Tucker introduced facilitators – Ted Johnson & John Hudgens

- Ted Johnson reviewed the values of the Council which are hope, respect, recovery, collaboration, inclusive and committed.
- Ted then asked the Council how Council leadership can be strengthened. The responses were engagement (work, each other, community), responsiveness, mission, vision, direction, focus, communicator, passion, compassion, connector, empowers others, understanding past(but visionary), strategic thinking, analytical, thick-skinned, diplomatic, innovative, takes initiative, pulse, purpose driven, mover/shaker, trustworthy, fearless.

- Sandra Mullins responded to Council members' questions regarding the role of the Council as it relates to the Council's mission and vision.
- Sue Smith shared a brief history of the Council and how children's representation became a part of the Council. This was followed by Cynthia Wainscott who explained how addictive disease came to be represented on the Council as well and some other things it has accomplish since its beginning.
- Ted reviewed ways in which we can strengthen Council engagement: please see PowerPoint

Day 1 Georgia
Onsite Visit Retreat

- Sandra Mullins gave a short farewell speech gift to Dawne Morgan who is retiring from DBHDD and her role as liaison to the GBHPAC.
- Dawne Morgan shared with the GBHPAC a short history of how the Council has evolved: it started as a requirement for the block grant from the federal government, the feds mandated that the states had to have an advisory Council. A mental health planning and advisory council was formed out of the federal mandate. A great relationship formed between the state and the mental health and advisory Council. The state was always able to showcase the work done with the Council to the federal government. Georgia was seen as a state that was innovative and led the rest of the states in many ways. The Mental Health Planning and Advisory Council eventually became the Behavioral Health Planning and Advisory Council after addictive disease was included. In partnership with the Council funding was obtained to provide for services for children. The peer movement also came about during this period and now there are peer specialists for adults, youth and parents.
- Ted then asked the Council how they know that they are relevant. Some of the responses given were, broad perspectives, people know what it is, what it does, its impact, It has specific impact in many areas, the Council's work is known beyond Georgia, it is relevant if it listens to the needs of the communities, it documents accomplishments and share that information, provides next steps in response to current and emerging needs, it's relevant if all members feel engaged, and understood their roles.
- Another question Ted asked was to whom do you want GBHPAC to be visible to? Responses were providers, legislators, stakeholders, families, other advisory groups, other agencies and leaders, the feds, people on behalf of whom the work is being done, young adults,
- The Council commented, other ways to increase visibility such as grants, other social media, statewide organization and events, partner with groups, do public" campaigns, tables at exhibit area at conferences, pop-culture, ???, Increase the number of young people on the Council, to engage understand their perspectives and ideas, think broadly in terms of young people, identify ways to support involvement, go to younger groups.
- Division reports for July are below.

BHPAC Office of Adult Mental Health

BHPAC Office of Addictive Diseases 7

BHPAC Office of Children Young Adu

OCYF April Infographic 2018.pd

SOC Infrastructure Brief_4-9-18.pdf

BHPAC Office of Federal Grant Progr

With no other announcements or business, the Chair called the meeting to an end at 4:00pm.

Meeting Adjourned

July 11

Members Present: Linda McCall, Sandra Mullins, Yvette Sangster, Jean Toole, Sue Smith, Pierluigi Mancini, Bertrand Brown, Sharon DeMille, Jean Olshefsky, Jewell Gooding, John Shereikis, Faye Taylor, Prince Moorman(for Cassandra Price), Lucy Hall, Ellyn Jeager, Ron Koon, Amy Kuhns, Cynthia Wainscott, Mary Shuman (for Tony Sanchez), Thom Synder,

Department Staff: Jill Mays (for Terri Timberlake), Danté McKay

Guest: Colleen Mousinho, Harvinder Makkar, Jennifer Hogan, Felicia Hardy, Ted Johnson, John Hudgens

Introductions, Moment of Silence

The Chair, Sandra Mullins called the meeting to order and commenced with introductions followed by a moment of silence.

- Ted mentioned it is very important that newcomers have mentors to guide them on the Council
- Pierluigi Mancini stated, the department division reports should be actionable. He commented that in the past the Council usually requested information from the state that the Council felt was informative. Such as what percentage of adults received a certain kinds of services etc.
- Ellyn Jaeger recommends that the Council should not wait until the November elections. Once the outcome the Republican runoff has been decided the chair of the Council along with a few members should make it a point to visit the winner of the Republican race to introduce them to GBHPAC as well as make a point to visit Stacy Abrams as well.
- Ted asked what are and the components of a committee. The responses were, they should be a purpose for each committee (related to vision and mission). Size/membership - how many individuals on the committee. If it's too large that may hamper progress and if it's too small nothing gets done. Representation: stakeholders will be impacted by the issues. This was followed by the question, does someone without children get to serve on the children's committee? Perhaps it depends on the person's interest. Another aspect of the committee is meeting structure . Additionally skill sets, knowledge, balance, good listener, have time to work, life of a committee, resources.

- What should GBHPAC committees be composed of? services (access, utilization, and availability), legislative, nominations, membership, prevention, Age groups (child, young adults, adults, aging)
- Why is it important that People who are not Council members may serve on committees? - Ted explain this is important because they are volunteers, they get acquainted with the Council, and it's a good way to recruit new members, it's a good way to identify people who will be good members. Please see PowerPoint below.

Day 2 Georgia
Onsite Visit Retreat

With no other announcements or business, the Chair called the meeting to an end at 3:00pm.

Meeting Adjourned

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Georgia Parents Support Network
1395 Metropolitan Pkwy SW
Atlanta, GA 30310
September 11, 2018
AGENDA

10:00 a.m. **Welcome and Introductions – Sandra Mullins, Chair**
Moment of Silence
Respect Institute Graduate – Toyia Mather

10:30 a.m. **Vote on Updated By-laws – Jean Toole**

11:00 a.m. **Division Updates**
Adult MH – *Terri Timberlake*
Addictive Diseases – *Prince Moorman*
Office of Recovery Transformation – *Mary Shuman*
CYF – *Danté McKay*
Deaf Services – *Candice Tate*
Federal Grants – *Dawne Morgan*

11:45 a.m. **GBHPAC Announcements – Sandra Mullins**

12:15 p.m. **Lunch**

1:00 p.m. **DOJ Updates and Housing – Cynthia Wainscott**

2:00 p.m. **TA Call-In with SAMHSA**

3:00 p.m. **Meeting Adjourned**

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Georgia Parents Support Network, Inc.
Atlanta, GA
Meeting Minutes
September 11th, 2018

Members Present: Rebecca Blanton, Bertrand Brown, Neil Campbell, Sharon DeMille, Jewell Gooding, Alan Huth, Erika Johnson, Ron Koon, Michael Link, Linda McCall, Sandye Mullins, Jean Olshefsky, Bob Poston, Tony Sanchez, Yvette Sangster, John Shereikis, Sue Smith, Faye Taylor, Jean Toole, Cynthia Wainscott, Patrick waters

Members Present by Permanent Alternate: Monica Johnson (for Judy Fitzgerald), Jennifer Hogan (for Thom Snyder), Yomi Makanjuola (for Cassandra Price)

Members Absent: Eleanor Brown, Mary Davey, , Bradley Grover, Ellyn Jeager, Amy Kuhns, Pierluigi Mancini, Keith Bostick, Steve Spivey, Sharon Jenkins Tucker

Department Staff: Jill Mays, Danté McKay, Dr. Terri Timberlake

Guest: Toyia Mather, Aisha Northington

Welcome and Introductions

Sandye Mullins called the meeting to order and ask those in attendance to introduce themselves. After the introductions the Chair asked for a moment of silence to remember those whose lives were taken on 9/11/2001.

Respect Institute Graduate: Toyia Mather

Respect Institute speaker Toyia Mather shared her recovery story entitled "Come out Come out Wherever You Are". The Respect Institute empowers those in recovery to share their recovery journeys, educating people about mental illness and helping to eliminate stigma.

Review and Approval of Minutes

The Chair Sandye Mullins made a motion to approve the July minutes. Minutes were approved.

Commission's Update: Monica Johnson

Monica introduced Jill Mays as the official department liaison to the Council and explained why Jill's official title has been changed from Director of Federal Grants and Special Initiatives to Director of Federal Grants and Cultural Linguistic Competency. Monica said Cultural Competency has been a frequently requested service under many of the grants that the department receives. However, there have been a number of barriers to being able to completely satisfy this particular requirement such as funding and other resources. Jill's office will be in a position to implement programs that provide cultural and linguistic competency training. Monica also stated that September was National Recovery Month and Suicide Prevention Month. The department is embarking on a Suicide Prevention Campaign

with Cumulus Radio, starting in the month of September and running through the holiday season, which is peak time for suicides. This partnership is with The Bert Show on Q100 radio station in Atlanta. PSA's will be run on The Bert Show, as well as in movie theaters. It was also revealed that there has been a dramatic increase in the number of people served by supported housing. In partnership with DCA, DBHDD has been able to expand the federal and state housing voucher program. Monica conveyed that Gateway Behavioral Health Services in Brunswick has one of the best crisis service centers in the State. One of the key factors in their success is having a CPS available to support the person in crisis the moment they walk in the door.

Office of Children, Young Adults and Families (OCYF) Partnership with GSU: Danté McKay

Danté spoke about his collaboration with The Center of Excellence for Children's Behavioral Health (COE) at Georgia State University, there were three areas covered. The first area that was covered was System of Care Values and Principles, this area has evolved over the last 30 years. There are certain values and principles that can be pulled out of the framework such as; Spectrums of Community-Based Services and support that is organized into a coordinated network. This network builds meaningful partnerships between families and youth and addresses cultural and linguistic needs in order to improve functioning at home at school, in the community and throughout life. Over time these values and principles have been used to form Georgia's formal system of care framework, the Behavioral Health Coordinating Council which is immortalized in Georgia law 37-2-4. The purpose of the Council is identifying overlapping services regarding planning and policy issues in the behavioral health system for both kids and adults. The other two areas are Georgia System of Care Framework and Georgia System of Care State Plan. Georgia State University provides backbone support for a variety of areas including IDT and data collection. The work group for school based mental health collected data from 700 school counselors throughout the State. It was discovered that one third of the schools surveyed had some sort of school based mental health services such as counselors embedded in the school, prevention or self-care related initiative. The payer determines a child access to services. In order to help families and youth understand the system, a step-by-step navigation guide was created for them from the perspective of families and young adults. Danté spoke about the Governor's Commission on Children's Mental Health. One of the recommendations was the expansion of the Georgia Apex Program in the last legislative session this recommendation received $4.29 million. Danté mentioned the primary functions of the IDT is to provide a strategic roadmap for Children Services. There is work that is relational to evidence based practices as well. References are housed on The Center of Excellence website. The timing of The System of State Care Plan aligned well with the forming of the Commission. This led to eight recommendations being returned by the Commission. Some of the recommendations were to further expand the APEX program. There was also a recommendation to form both supportive employment and supportive housing programs. Over $3 million was set aside to form an evidence informed model, which allows for more flexibility. Included was more funding for peer support, which allowed for an increase in staffing, youth and parent CPS. Future crisis respite homes will be funded as well. More trainings will be offered, including Trauma Informed Care. Temporary funds were given to sustain Wraparound services and extended eligibility has been given. The Opioid recommendation received $1 million and the Suicide Prevention Program received $1.4 million. Funding will also become available to ensure there is staff available to answer the warmline at The Georgia Council on Substance Abuse 24 hours a day, as opposed to the restricted hours they currently have. Local Interagency Planning Teams (LIPT) were created in 1990. These multi- agency teams meet to provide supports and

services that are all voluntary and unfunded. Currently, there are more than 130, throughout the State of Georgia. Membership includes the parents, youth, community and mental health agencies, department of family and children services, GVRA etc. Danté mentioned that the Block Grant has supported services that are a part of the continuum of care and the goal is to move them to sustainability. *For further information see report embedded below:*


09.11.18_BHPAC.pdf


SOC_Poster.pdf

Committee's Report

Cynthia Wainscott, Chair of CYF Committee, stated the committee has decided on bi-monthly meetings, which would be held the first or last week of the month. There will be phone calls before each meeting. The agenda for the first meeting includes understanding the rules of Block Grant, goal setting and developing priorities.

Jean Olshefsky Chair of Adult Committee had the opportunity to meet everyone. This committee will meet every other month. October and December meetings dates have already been set. Meetings will discuss priorities and agendas. Also, learning what's covered in the Block Grants, developing leadership and others to invite in to further the GBHPAC Mission. As well as finding out the exact role of GBHPAC under the block grant.

Policy and Legislative Report: Jewell Gooding

Jewell talk about a lawsuit against the Affordable Care Act (ACA) regarding the constitutionality between Texas and Azar Different strategies of closing the Medicaid coverage gap is being considered with some conservatives even considering alternatives like waivers. Grady Hospital is doing a pilot program in reference to the waivers. Another issue of concern is the rural hospitals. Due to the low population base they are not making enough money to survive and are therefore closing or at risk of closure. Certificate of Need conversation has related to the hospitals. There will be more information coming on the certificate of need. Some of the issues brought from previous legislative sessions, are retrospective ER policies, there is also a joint study committee on Tetrahydrocannabinol (THC) low medical oil access. As well as another study committee on Kratom to examine the effects is a drug that is highly addictive that is used to get people off of other drugs. There are also study committees examining service animals for those who are mental and physically impaired. Study committee for dyslexia. Georgia Physician Practicing Association (GPPA) is ready to look at getting psychiatric advanced directives passed, this bill may be reintroduced and helps with recovery oriented practices. Another bill that may pass through this year is for Emergency Medical Technician (EMT) and Emergency Medical Services (EMS), to looking at what their role is exactly in the public mental health system versus trying to force a particular intervention (1013). Opponents are working hard to try to help Senators understand the consequences of trying to implement interventions of such magnitude. Criminal Justice Reform is being worked on by MHA of GA and engaging different community groups to help support or maximize the resources that do exist. Parity is reaching its 10thyear. In 2008, there was the mental health parity and insurance act, called the Better Parity Law. This law required insurance to cover illnesses of the brain such as depression and addiction, no more restrictively than illnesses of the body like cancer and diabetes.

Divisions Updates

Adult Mental Health: Dr. Terri Timberlake

Dr. Timberlake shared that Gateway Behavioral Health Services will be operationalizing the Savannah Behavioral Health Crisis Centers (BHCC) by early summer of next year. Additionally, Avita has also been looked at to provide the next be BHCC in the Gainesville area. DBHDD will provide funding to the CSB's to hire Housing Outreach Coordinators who will support individuals who are transitioning from prison, jails and emergency rooms to provide supported housing. The Housing Outreach Coordinators will not be providing services to individuals who are receiving outpatient services. She also mentioned that twelve positions across specific CSB's have been funded for the Housing Outreach Coordinators. The first housing outreach coordinator was hired in December, the last was hired in April. *For further information see report embedded below:*

BHPAC Office of Adult Mental Health

Addictive Diseases: Yomi Makanjuola

Yomi (Director of Treatment Services for the Office of Addictive Diseases) was filling in for Prince Moorman. Yomi reported The State General Assembly gave the Office of the Diseases $40 million for recovery supports as oppose to treatment. There will be a similar mechanism put in place for individuals to receive recovery support, as was the case with teenagers and clubhouses. Georgia Council on Substance Abuse will be the technical assistance provider for this project. There will also be a residential treatment program for young adults. It will be the first in the State of Georgia it will target youth from age 18 to 26. *For further information see report embedded below:*

BHPAC Office of Addictive Diseases 9

Office of Recovery Transformation: Tony Sanchez

Tony mentioned that September is National Recovery Month and there will be 20 events scheduled across the State for the entire month. These events will be funded through DBHDD's Office of Addictive Diseases. Tony added that each of the Addiction Recovery Support Centers are required to be run by individuals with the credential of CPS-Ad or CARES. In addition, the Executive Director of these organizations starting salary will be over $50,000 with the support staff salary starting at over $35,000. Tony hopes the salaries at the Recovery Support Centers will have a broader effect of raising salaries for CSB's and other providers. Tony then mentioned that the peer mentors who are trained by Georgia Mental Health Consumer Network, provide support to individuals transitioning from state hospitals back into the community. These positions were originally part-time and now there is funding available to provide the peer mentors who work at three of the five State hospitals full-time positions with the goal of making all the peer mentors at the five hospitals full-time employees. One of the aims of these full-time positions is to allow for more one-on-one time with the peer mentor and individuals receiving services. *For further information see report embedded below:*

2018.09.11 BHPAC
Office of Recovery Ti

Children, Young Adults, and Families: Danté McKay

Danté mentioned that there is a Southeast School Based Mental Health Coalition that includes all the South Eastern States. Danté said he is excited that Georgia is a part of this group and look forward to contributing to the coalition and also learning from them. Another development Danté spoke about was the four mental health juvenile courts. The State System of Care program is looking to provide better support to the juvenile mental health courts. The four courts are located in DeKalb, Fulton, and Chatham and Henry counties. *For further information see report embedded below:*

BHPAC Office of
Children Young Adu

SOC Infrastructure
Brief_4-9-18.pdf

SOC_State Plan
Brief.pdf

Action Item: Danté suggest inviting the Center of Excellence to do a presentation for BHPAC

Office of Federal Grants: Jill Mays

Jill said that the First Episode Psychosis Project has started a new program and New Horizons in Columbus, Georgia. Staff training and outreach will begin the in the month of September. Furthermore, the DBHDD completed its work with NASMHPD for the Transformation Transfer Initiative which centered on Recovery Oriented Cognitive Therapy (CTR). Providers across the State were trained in CTR. Jill pointed out that not only clinical staff was trained in CTR, but peers as well. SAMHSA is changing the way they do technical assistance contracts. They are working on a regional system where the technical assistance dollars would go to universities who would then hire consultants to provide TA. Regarding the Block Grant the mini-application for 2019, Jill said it was submitted on September 4. There were new Block Grant rules pertaining to Behavioral Health Planning Council composition. One of the stipulations were that a council member cannot represent two categories. For example, an individual who is a provider cannot also be listed as someone in recovery. All Council members can only have one assigned role. Jill also announced that DBHDD was awarded to large grants. The first is called Georgia strong ($3.1 million) spanning three years for intensive outpatient services for new mothers with substance abuse challenges. This program will be housed at Hope House. It will cover individual and group substance abuse counseling, parenting support and education, employment and educational assistance, family support and education, Peer to peer support, relapse prevention education, intensive case management, transportation, referral services, childcare and housing assistance, linkage to OB/GYN psychiatric care and home visits by nurse and a parenting coach. They are slated to serve 136 women over the life of the grant and offer statewide services. The second grant is four year $11.3 Million grant from SAMHSA to expand the System of Care project to rural communities. DBHDD will be working with Aspire and CSB of middle Georgia to carry out this project. This project should be up and running by December. *For further information see report embedded below:*

BHPAC Office of Federal Grant Progr

Action item: Jill suggest discussing these two large grants further during the January meeting.

New Businesses and Announcements

Sandra Mullins: GBHPAC will be looking into revising its orientation manual. In addition, we will be looking at getting new individuals involved in the Council or to serve on the committees, along with creating a website for the Council. The Council will be looking at these issues starting in January. The consultants that facilitated GBHPAC March and July retreat made a recommendation for different department and divisions to give reports to GBHPAC. As an example, the Department of Education can give a report once or twice a year as well as other state agencies that have a seat on the Council. Please collaborate with Jean Toole if you're interested in presenting a report from your agency.

Jewell Gooding: Mental Health America of Georgia launching the mental health awareness campaign for World Mental Health Day on October 10. MHA of GA is currently looking for individuals who would like to discuss the current state of their mental health. The goal is to help people have intentional conversations in the community about mental health.

Jill Mays: From the Office of Prevention, the Governor's Red Ribbon Campaign will kick off on October 18 at the Barnes amphitheater in Mableton. Jill also acknowledged Nakia Valentine, A DBHDD employee who suddenly passed away. Nakia was the Director of Garrett Lee Smith Suicide Prevention Program. DBHDD's Office of Prevention has established Youth Suicide Prevention Leadership award in Nikita's name. This information is in your packet and how to nominate a deserving youth. DBHDD's collaboration with other departments is announcing its annual 5K recovery run/ walk at Grant Park.

Jean Olshefsky: GCAL was featured on CNN in an article and on video during International Suicide Prevention Week.

Faye Taylor: NAMI Georgia has three walks scheduled for October. Two of the walks will be on October 6.The first will be at Atlanta Clark University circling around the Capital and the second will be in Moultrie, Georgia. The third walk will be held in Gainesville, Georgia.

Cynthia Wainscott: Cynthia created a presentation about what happened in Georgia because of the DOJ settlement. She also said we need to celebrate what has happened and the amazing transformation that occurred in Georgia as a consequence of the settlement. *For further information see presentation below:*

Wainscott Panel Presentation.pptx

Meeting Adjourned

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

GBHPAC vision is "*To be a leading force that strives for an accessible, affordable, comprehensive, and integrated recovery-oriented behavioral health system that cultivates and supports healthy and diverse communities in a culturally and linguistically inclusive manner.*"

GBHPAC mission is "*To bring individuals representing children, adults, peers, and families together to educate, advise, advocate, and monitor the behavioral health system to ensure an effective recovery-oriented system of care.*"

Care and Counseling Center of Georgia
1814 Clairmont Rd
Decatur, Georgia 30033
November 13, 2018
AGENDA

10:00 a.m. **Welcome and Introductions – Sandra Mullins, Chair**
- Moment of Silence
- Respect Institute Graduate – Lilian Davis
- Public Comment

Approval of Minutes for September 2018

10:30 a.m. **Expectations for the next year**

11:00 a.m. **Committee's Reports – Areas Of Interest, Challenges and Setting Goals**
- CYF committee – Cynthia Wainscott
- Adult Behavioral Health Committee – Jean Olshefsky
- Advocacy Committee – Jewell Gooding and Neil Campbell
- Nominating and Membership Committee – Jean Toole

12:00 p.m. **Lunch**

12:20 p.m. **Commissioner's Update – Judy Fitzgerald**

1:00 p.m. **Program**

1:30 p.m. **What are You Proud of and Challenges for the New Year ?**
- Adult MH – *Terri Timberlake*
- Addictive Diseases – *Prince Moorman*
- Office of Recovery Transformation – *Tony Sanchez*
- CYF – *Danté McKay*
- Federal Grants Data Reports – Jill Mays

2:00 p.m. **New Businesses and Announcements**
- Orientation of Members in January 2019

3:00 p.m. **Meeting Adjournment**

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Care and Counseling Center of Georgia
Decatur, GA
Meeting Minutes
November 13, 2018

Members Present: Sharon DeMille, Judy Fitzgerald, Jewell Gooding, Lucy Hall, Alan Huth, Erika Johnson, Amy Kuhns, Pierluigi Mancini, Linda McCall, Sandye Mullins, Jean Olshefsky, Yvette Sangster, Sue Smith, Thom Snyder, , Jean Toole, Cynthia Wainscott,

Members Present by Permanent Alternate: Vickie Cleveland (for Rebecca Blanton), Prince Moorman (for Cassandra Price), Colleen Mousinho (for Keith Bostick), Mary Shuman (for Tony Sanchez)

Members Absent:, Bertrand Brown, Eleanor Brown, Neil Campbell, Mary Davey, Bradley Grover, Ellyn Jeager, Ron Koon, Michael Link, Bob Poston, John Shereikis, Steve Spivey, Faye Taylor, Sharon Jenkins Tucker, Patrick waters

Department Staff: Jill Mays, Danté McKay, Dr. Terri Timberlake

Guest: Lillian Davis, Shelli Keller, Toyia Mather

Welcome and Introductions

Chair Sandye Mullins called the meeting to order and began the meeting with a meditation poem by Mary Oliver called "Journey". Sandye also shared that she will be retiring from the Care and Counseling Center of Georgia at the end of December. This was then followed by introductions by all present at the meeting and a moment of silence.

Respect Institute Graduate: Lillian Davis

Respect Institute speaker Lillian Davis shared her recovery story entitled "My Three Lives". The Respect Institute empowers those in recovery to share their recovery journeys, educating people about mental illness and helping to eliminate stigma.

Review and Approval of Minutes

The Chair Sandye Mullins made a motion to approve the November minutes. Minutes were approved.

Expectations for the next year

The chair of GBHPAC stated that the Council will be receiving reports from the various committees, as well as getting more involved in areas of interest within the state. The committees will be using this time to gather feedback from the community. In addition, utilizing the knowledge gained during GBHPAC spring and summer retreats.

Committee's Report

Cynthia Wainscott, Chair of CYF Committee, spoke about the importance of learning how the Block Grant dollars are spent as a first priority. Danté McKay gave some clarification on how those funds were to be used for children, young adults and families that are channeled through The Department of Education. The next priority that Cynthia spoke about was learning to write a plan for the next two years. Cynthia sought out Jill Mays support with writing the plan. The committee is dedicated to completing this task as it will be beneficial to them. These written priorities will be a guide to the CYF committee on how to spend funds based on the amount available to them at any given time. It will also help them to identify what the top priority is and the necessary funding for that priority. Cynthia is hopeful that the department will also be knowledgeable of other funding streams. $3.8 million in funds that the block grant has been supporting will now be available due to Medicaid coverage of the System of Care Services. Therefore the Council will have some discussions with the department about how the $3.8 million will be spent next year.

Jean Olshefsky, Chair of Adult Committee had the opportunity to meet committee members. The committee will meet every other month. Meeting dates for October and December have already been set. The goals are to discuss priorities, agendas, developing leadership, as well as learning what is covered in the Block Grant. In addition to finding out the exact role of GBHPAC under the block grant. The committee is looking at ways of how they can best support the department, while giving input based on community feedback. Jean thought it would also be nice to have some offshoot committees within the adult committee to support the entire mission of GBHPAC. Moving forward, the adult committee is developing who they are and what their mission is going to be as a subcommittee within the planning council.

Jewell Gooding, who reported for the Advocacy Committee, stated that currently there may be a recount or runoff between Brian Kemp and Stacy Abrams for the governor's seat. Brian Kemp has declared himself the governor and resigned from his former role. There is a special session this week in order to determine what to do with the funds that sits in the governor's budget. If Brian Kemp is declared the governor much of those funds in the governor's budget will be set aside for Kemp to spend for his session. However, if Stacy Abrams is declared the governor there is a likelihood that those funds in the governor's budget will be spent or dramatically reduced and Stacy Abrams would not be able to utilize those funds. Jewell also mentioned that there are 38 new legislators elected. Eleven seats were flipped to the Democrats and three seats went to the Republicans. There will be an upcoming meeting, to orient the new freshman legislators in December. Jewell pointed out that this will be a great opportunity to introduce the freshman legislators to the issues surrounding the behavioral health system. NAMI Georgia and Mental Health America of Georgia will both be present at this meeting to speak to the new legislators.

Jean Toole, Chair of Nominating and membership committee spoke about the committee's effort to revise the orientation manual and the orientation process. The committee reviewed orientation manuals from other States and came up with a list of topics that should be included in GBHPAC orientation manual.

- Council mission and vision
- A copy of the bylaws

- Council history and purpose
- Councilmember expectations
- Member terms, officer terms, attendance policy, committee participation, duties of Council members and officers duties
- List of Council officers with their full terms clearly stated
- Councilmembers with their terms clearly stated
- Council meeting schedule
- The travel reimbursement policy and forms related to it

Additionally, Jean mentioned a resources section where we will have a copy of the planning council 101, links to the Council website, DBHDD's regional map, DBHDD's acronyms and abbreviations, the department's organizational chart, links to GCAL and other websites where individuals can find resources or services.

Action Item: ***If anyone has any ideas or suggestions about what should be in the orientation manual please don't hesitate to contact Jean Toole regarding your input.***

Divisions Updates

Adult Mental Health: Dr. Terri Timberlake

Dr. Timberlake highlighted the Annual Respect in Recovery Walk and its success. There were a number of agencies that celebrated the collaborative efforts. This was a project of the coordinating council transitioning committee. Work is being done to expand the behavioral health crisis centers. Gateway will operate one and the department is in the early stages of awarding a contract to Avita. Dr. Timberlake is proud of the department's compliance in regards to the housing settlement. There has also been tremendous growth over the last seven years in services through the DBHDD. She mentioned that funding is somewhat of a challenge. There has not been a funding increase for CORE services, like basic outpatient services, peers, nurse practitioners etc. It's important for those who can advocate to do so. The department has received additional resources to provide the Georgia Housing Voucher, to those who meet the criteria. *For further information see report embedded below:*

BHPAC Office of
Adult Mental Health

Addictive Diseases: Prince Moorman

Prince shared that DBHDD received a few million dollars from the State to fund Recover Support services. These funds were used to support 16 providers in addition to the other 5 recovery support centers that already exist. With the launch of the Recovery support Centers each provider was asked to do a PowerPoint presentation, highlighting their strengths, aspirations, results and expectations. Thereafter, there was a workshop for those 16 providers who started services around September. Nichols Estabrooke was hired as Project Officer to oversee these services. Service guidelines are being

worked on for those providers and how the services will be presented. A systematic approach will be taken. Prince also mentioned there are 9 clubhouses with the capacity to serve 20 youth at each clubhouse. Furthermore, there are over 100 accountability courts across the state. Handouts were given out to share information about the available programs and recovery supports. *For further information see reports embedded below:*


BHPAC Office of Addictive Diseases 1


Office of Addictive Disease handout.pd

Commission's Update: Judy Fitzgerald

Commissioner Fitzgerald, utilized handout to illustrate the transformation story and progress the department has made over the last 10 years. However, there are still several things that are pressing for the department and around the country. The commissioner stated there has been a tremendous investment in outpatient Core services, which may reduce the need for crisis services. Currently, our country is facing an Opiod crisis, which is very dramatic. DBHDD is the state's health authority responsible for providing the funding for community services to address this crisis. The department received 11.8 million over the last two years and 20 million will be allotted for the third year. There has been a lot of training and education that the funds have been used for. Naloxone kits are been utilized and over 900 have been made available and are being used. Grant funding is being used to make Medicated Assisted Treatment (MAT) an option available for those who are uninsured or underinsured. Meth and cocaine usage are back on the rise. Alcoholism, is still the largest driver of addiction challenges in the state of Georgia according to the Commissioner. There is not a plan to build any more mental health beds in our hospitals. The Commissioner spoke of having more information about where the needs currently are. Forensic population is a growing area of interest and concern. This is a priority for DBHDD. Furthermore, the aging population, is an area where more preparation needed. The system is not fully ready for the aging population. The Commissioner expressed making this a priority on her list to work with the aging population and working in collaboration with the Department of Human Services, who serve the aging community. The state has opened up memory assessment centers through Emory University. The State partnered with Emory to allow older adults a place to go when they don't know what is happening with them. It can be anything from dementia to depression and other things they may be dealing with. She also stated the most pressing issue is the workforce shortage in Developmental Disabilities, Mental Health and Addiction and how these shortages are crippling the system. The workforce is stretched to the max in the hospitals, there is a need for more staff in these areas and community based services as well. DBHDD budget has been approved by the DBHDD board and it will be taken to the general assembly. This budget is DBHDD's portion of the Governor's budget. The budget is not official, as of yet. The priorities that are best reflected through the budget are (1) high quality care and the three ways that will be vetted thought the budget request. (2) CORE services is listed. (3)Housing services. (4) Forensic services both in community and hospitals, which is the only area of the hospital which is growing. Annualizations, are not usually a one year funding opportunity and are meant to be ongoing. $18 million is needed to keep it on track. There is an ongoing fund of $15 million for workload adjustments for CORE services. In conclusion, the Commissioner said that there is a 2%

request. Not every agency received the 2% increase. There will be continued investment in crisis bed infrastructure and addictive disease residential beds, which are all community based. Crisis stabilization units were anticipated to serve 70 % psychiatric crisis and 30% detox and addiction. In fact, the opposite happened 70% of the beds are being used for residential addiction and detox and 30% for psychiatric crisis. There is also ongoing commitment for housing voucher. The criteria was written into the settlement agreement and it defines the population that is eligible. There are more residential beds coming for addictive disease. One of the reasons that people stay in crisis beds longer, is because it takes longer for someone to detox the Commissioner noted. *For further information see report embedded below:*

11.13.2018_Georgia Behavioral Health Pl

Office of Federal Grants: Jill Mays

Jill begin by summarizing the report from the Office of Federal Grants for The First Episode of Psychosis. The TTI grant (Transformation Transfer Initiative). Jill mentioned that the decision will be made at the end of the month if the application is approved for $ 150,000. Project LAUNCH is (Linking Actions for Unmet Needs in Children's Health), serve children up to the age of 8 and includes prevention. This is a combined grant with the Department of Public Health. The block grant mini application is still under review and the adjustments have to be made before approval is given. The final allocation was given in October. June is the desired date for the Nominating Committee to have any issues resolved and the fact that GBHPAC doesn't have an appropriate percentage of consumer involvement. This is to satisfy the new changes implemented by SAMSHA. *For further information see report embedded below:*

BHPAC Office of Federal Grant Progr

Action Item: ***Invite Dr. Druss to speak to the Council at a future meeting about SAMHSA new regional Technical Assistance Center at Emory University***

DBHDD Behavioral Health Budget Manager: Shelli Keller

Shelli shared that DBHDD was awarded $22.7 million for Federal Fiscal year 2018 Block Grant for a two-year term that began October 2017. For Federal Fiscal year 2019 the Block Grant awarded was $22,053,331 which is a reduction from the prior year of $732,478. Each award is a plan of two years, SAMSHA usually gives input as to what they would like to see the funds used for. It was revealed that Peer Support funding has been split 40% state and 60% federal. The service plans from the prior years are always looked at, like Mental Health Courts and other allocations for training as well as Planning Council funding. Shelli stated that additional mental health club houses have been added, First Episode Psychosis earmark requires that DBHDD spend no less than 10% for those service providers. Furthermore, funding will increase for those services and additional providers will be added. The State's spending for children's mental health as of 1984, was no less than $8 million but actually exceeds more than $50 million annually today. *For further information see report embedded below:*

Block Grant Expenditures.pdf

Office of Children, Young Adults and Families (OCYF) Partnership with GSU: Danté McKay

Dante's office received the System of Care Grant worth $11 million over four years for a proposal that was submitted two years ago. In addition to the priorities mentioned by the commissioner earlier, there is also a workgroup led by the division of housing program high utilization management program. This is designed to help understand what the barriers are and why people repetitively cycle through the system. Work is being done collectively and individually in children's services so that the gaps may be closed and services will be rolled out differently than before. Dante mentioned that finding the right pace is important, as opposed to getting things done quickly. Youth Mental Health First Aid training is one of interest. There is a need for enhanced distribution of this training. The Department of Education provided NAMI (National Alliance on Mental Illness), with a grant to provide Youth Mental Health First Aid training. Feeding programs are also needed during the summer time because food costs become excessive. DCAL (Department of Early Care and Learning) and the Department of Education, have a partnership to work with organizations and nonprofit entities to provide the food. Danté spoke about the Mental Health Resiliency Support club and one of the things they offer is, providing nutritious meals for youth and families. *For further information see report embedded below:*

BHPAC Office of Children Young Adu

Office of Recovery Transformation: Mary Shuman

Mary talked about the depth of peer support services and the number of places where Certified Peer Specialist (CPS) work in our system. If the different types of CPSs are taken into account such as CPS parents, CPS youth, CPS AD, CPS whole health. DBHDD have certified over 3300 CPSs to date. In addition, there are nine Medicaid billable services and their services definition require that these nine services be delivered by Certified Peer Specialists. Mary mentioned that there are a lot of other services provided by CPSs and there is often times a misperception of their role in traditional services. The Office of Recovery Transformation is providing education about peers in clinical environment. Developing the peer support workforce is one of the Office of Recovery Transformation main priorities. Another priority, is helping the behavioral health workforce transform their services into a recovery oriented model. Mary explained that her office is in the fifth year of recovery focused training initiative where they are now working with Tier 1 providers. The Office of Recovery Transformation is providing Tier 1 providers a year of coaching, training and technical assistance helping them develop their own recovery focused change teams within their agencies. Mary reports that these providers have done some phenomenal projects with this work that have increased the ability to serve more people and have also made services more enticing. The Office of Recovery Transformation initiative has a recovery orientation evaluation of the system and they were fortunate to be able to participate in Yale Universities' recovery oriented self-assessment survey. Providers were invited to participate in the survey as well. Georgia received one comprehensive report for the state. One of the interesting observations that Mary made was the principal that consumers be involved in all levels of the service system. Example from the Board

of directors all the way down. Interestingly, this principle was the lowest score that Georgia received. Therefore, there is a need to find ways to incorporate people receiving services at all levels of the service system. Another important point was shortages in the workforce, which is surprising because Georgia was considered an innovative State because of using Certified Peer Specialist. *For further information see report embedded below:*

BHPAC Office of
Recovery Transforma

New Businesses and Announcements

Sandye spoke about the new member orientation and how they could take a portion of time from the next meeting to orientate the Council in January 2019. Also, whatever is missing from the orientation manual will be discussed. CYF and Adult committees meetings need to be set up to receive support for the funds of $920,000. Jean and Cynthia agreed to set up conference calls with their respective committees.

Meeting Adjourned

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

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GBHPAC mission is "*To bring individuals representing children, adults, peers, and families together to educate, advise, advocate, and monitor the behavioral health system to ensure an effective recovery-oriented system of care.*"

Decatur Rec Center
231 Sycamore St
Decatur, Ga 30033
January 8, 2019
AGENDA

10:00 a.m. **Welcome and Introductions – Sandra Mullins, Chair**
- Moment of Silence
- Respect Institute Graduate – Ernest Brown
- Public Comment

Approval of Minutes for November 2018

10:30 a.m. **Sue Smith & Fam-VOC Survey**

11:00 a.m. **Steve Spivey – Chair of Statewide Leadership**

11:15 a.m. **GDBHDD and Committee Reports – Areas Of Interest, Challenges and Setting Goals**
- CYF committee – *Cynthia Wainscott*
- Adult Behavioral Health Committee – *Jean Olshefsky*
- Adult MH – *Terri Timberlake*
- Addictive Diseases – *Prince Moorman*
- Office of Recovery Transformation – *Tony Sanchez*
- Advocacy Committee – *Jewell Gooding and Neil Campbell*

12:00 p.m. **Working Lunch:** Committees meet

1:00 p.m. **Program – Orientation for all Members- Sandye Mullins**

1:30 p.m. **What are You Proud of and Challenges for the New Year ?**
- Federal Grants Data Reports – Jill Mays
- CYF – *Danté McKay*
- Nominating and Membership Committee – Jean Toole

2:00 p.m. **New Businesses and Announcements**

3:00 p.m. **Meeting Adjournment**

GBHPAC GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Decatur Rec Center
231 Sycamore St
Meeting Minutes
January 8, 2019

Members Present: Sharon DeMille, Jewell Gooding, Pierluigi Mancini, Sandye Mullins, Jean Olshefsky, Yvette Sangster, John Shereikis, Jean Toole, Cynthia Wainscott, Rebecca Blanton, Sherry Jenkins Tucker, Steve Spivey, Faye Taylor, Patrick Waters, Neil Campbell, Bertrand Brown, Erica Johnson, Tony Sanchez

Members Present by Permanent Alternate: Prince Moorman (for Cassandra Price), Colleen Mousinho (for Keith Bostic), Mary Shuman (for Tony Sanchez), Sarepta Archilla , Linda McCall, (for Brian Dowd), Lisa Pace (for Sue Smith), Harvinder Makkar (PA for John Shereikis)

Members Absent: Eleanor Brown, Mary Davey, Bradley Grover, Ellyn Jeager, Michael Link, Bob Poston, Lucy Hall, Alan Huth, Ron Koon, Amy Kuhns, Thom Snyder, Monica Johnson

Department Staff: Jill Mays, Danté McKay

Guests: Joel Slack, Ernest Brown

Welcome and Introductions

Chair Sandye Mullins called the meeting to order by opening with a moment of silence. Joel Slack then introduced the Respect speaker, Ernest Brown.

Respect Institute Graduate: Ernest Brown

Respect Institute speaker, Ernest Brown, shared his recovery story entitled "Why Me". The Respect Institute empowers those in recovery to share their recovery journeys, educating people about mental illness and helping to eliminate stigma.

Review and Approval of Minutes

November minutes were approved.

Sandye stated that she hopes to have someone from (GCAL), Georgia Crisis and Access Line present at the councils March meeting. Sandye also stated that she is hopeful that once the orientation manual is completely revised, there will be an orientation for all council members.

Family –VOC Survey

Lisa Pace (for Sue Smith) shared information about the Family Voice on Council & Committees (Fam-VOC), which is an assessment for organizational support for family voices. It was developed by FREDLA (Family Run Executive Director Leadership Association, Inc.) and is an online 15 minute, confidential survey. The survey is intended to gauge the extent to which councils, committees and advisory boards support the family voice by engaging and supporting family members to be active and influential. Lisa

asked for the council members to participate in completing the survey. *For further information see reports embedded below:*


Fam-VOC Flyer for Site Coordinators_ (


Fam-VOC Survey_14Jan2019.p

Steve Spivey – Chair of State Leadership Council

Steve Spivey, Chair of the Statewide Leadership Council, shared information with the council regarding a survey called Identifying Independence and Recovery Needs in Georgia. Steve talked about his experience caring for his 34 year old daughter who lives with special needs. Steve wants to have every person in Georgia complete the survey. The goal is to have 7700 of the surveys completed, so they can be analyzed and turned in to the commissioner. Steve mentioned that the survey was developed by leadership council members and it took 1 year to complete it in entirety. The deadline to have this survey completed is April 15. This survey is also available online and in Spanish. The hope is to eventually have the survey available in several different languages. To date, 1700 surveys have been returned to them but they are in need of more. Steve ended by asking council members complete the surveys via Survey Monkey. *For further information see report embedded below:*


Needs Survey PDF.pdf

Cynthia Wainscott, Chair of the CYF Committee, reported that the committee has set a meeting once a month and are working to develop priorities. Cynthia shared that November was a really exciting time for the CYF committee and in October they found out that there was $400,000 from SAMSHA and the decision had already been made that half of that amount would be for children and half for adults. Cynthia noted that Jill and Dante were helpful with the committee and they have met at least 2-3 times. Cynthia also discussed block grant process and application.

Jean Olshefsky, Chair of Adult Behavioral Health Committee, discussed the October committee meeting which included discussion regarding additional funding and potential uses. The committee decided to go with the recommendation of Dr. Timberlake which was to fund forensic peers and two mental health courts, looking at region 2 and 5 since there are no providers funded to serve the courts in that area. Jean noted that in future meetings the committee would discuss priorities.

Sarepta Archila (for Dr. Timberlake) gave a brief over view of the blended mobile crisis response that was operational as of January 1, 2019. They must arrive within 59 minutes on the site and consult with a medical professional prior to recommending intensive crisis support or behavioral intervention. The clinician must communicate all recommendations within 24 hours to all applicable parties involved and report monthly outcome statements. *For further information see report embedded below:*

BHPAC Office of
Adult Mental Health

Prince Moorman (Addictive Diseases) spoke about one of the providers, Lucy Hall (Mary Hall Freedom House) and the challenges they are facing from the City of Sandy Springs. Prince mentioned that the City of Sandy Springs is saying they are not in compliance with city laws. As a result, Lucy Hall is suing the City of Sandy Springs for discrimination. That program has been in Sandy Springs for 22 years and is the only state program in that area for women who have substance abuse disorder and are pregnant or with children. Prince asked if the council could come up with any realistic solutions to advocate and support Lucy. Mary Hall provides outpatient and residential treatment. Prince mentioned that it would be a grave injustice to lose that service. *For further information see report embedded below:*

BHPAC Office of
Addictive Diseases 1

Tony Sanchez (Office of Recovery Transformation) spoke about a Faith Based Initiative coming out of the Office of Recovery Transformation. There will be a forum this Saturday at Loudermilk Conference Center, from 9:30 A.M. -12:00 P.M. with more dates in the future.

For further information see report embedded below:

BHPAC Office of
Recovery Transforma

Jewell Gooding reported for the Advocacy Committee. Georgia has a new governor elect and the legislative session begins on January 14. Tom Crise, the past HHS (Health and Human Services) secretary will be joining Brian Kemp's team to work on Medicaid waivers. Grady Memorial Hospital is in a pilot project looking at Medicaid waivers and how they have utilized it in the integrated care models. There has been conversation regarding the eliminating of SNAP, Medicaid, and Childcare Subsidies. Advocates are looking at ways to maintain those funding sources to ensure people can have access. Another issue around the state is the certificate of need and the impact on hospitals in rural settings. That is in response to the hospitals, particularly in the rural settings where they do not necessarily meet the eligibility certificate of need. That has put a huge barrier on being able to sustain some of those rural hospitals. Jewell discussed the Healthy Housing Coalition which is supposed to help renters have healthy rental housing conditions and hold landlords accountable for their properties. Mental Health day at the Capital will be on February 8 and is hosted by Behavioral Health Services Coalition.

Neil Campbell announced that Recovery Day is at the capitol next Thursday January 17, 2019 at the Freight Depot from 10:00 A.M-2:00 P.M. Registration is available on the Georgia Council on Substance Abuse's website. Neil also stated there will be SAMSHA discretionary funding coming down for

Recovery Community Organizations and recovery support services in a treatment capacity within the next year.

Jill Mays (Office of Federal Grants) spoke about the Light Program and funding Grady Memorial Hospital and Viewpoint. *For further information see report embedded below:*

BHPAC Office of Federal Grant Progr

2019 BHPAC Mental Health Block Grant

Danté McKay (Office of Children, Young Adults and Families) talked about the block grant and how the block grant is applied. *For further information see report embedded below:*

BHPAC Office of Children Young Adu

Jean Toole (Chair of Nominating and Membership Committee) spoke about the new membership process and orientation manual which will hopefully be ready at our next meeting.

New Businesses and Announcements

Jill mentioned that the Department is making a concerted effort to not use acronyms when they send reports. Faye mentioned that Benchmark, has left region 2. Cynthia encouraged council members to send out those two surveys discussed today.

Meeting Adjourned

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

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Harris Tower
233 Peachtree St., NE 2nd floor
Atlanta, Ga 30303
March 12, 2019
AGENDA

10:00 a.m.	**Welcome and Introductions – Sandra Mullins, Chair** • Moment of Silence • Respect Institute Graduate – Mluv Wallace • Public Comment **Approval of Minutes for January 2019**
10:30 a.m.	**GCAL Tour and Presentation with Wendy Farmer**
12:00 p.m.	**Lunch:** Committees Meet
1:00 p.m.	**GDBHDD and Committee Reports – Areas Of Interest, Challenges and Setting Goals** • Nominating and Membership Committee – *Jean Toole* • CYF Committee – *Cynthia Wainscott* • CYF – *Danté McKay* • Adult Behavioral Health Committee – *Jean Olshefsky* • Adult MH – *Terri Timberlake* • Addictive Diseases – *Prince Moorman* • Office of Recovery Transformation – *Tony Sanchez* • Advocacy Committee – *Jewell Gooding and Neil Campbell* • Federal Grants Data Reports – *Jill Mays*
2:15 p.m.	**Orientation Manual-Jean Toole**
2:30 p.m.	**Recovery Language – Neil Campbell and Sherry Jenkins Tucker**
2:45 p.m.	**New Businesses and Announcements**
3:00 p.m.	***Meeting Adjournment***

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Harris Tower
233 Peachtree St., NE 2nd floor
Meeting Minutes
March 12, 2019

Members Present: Rebecca Blanton, Bertrand Brown, Neil Campbell, Sharon DeMille, Alan Huth, Michael Link, Pierluigi Mancini, Sandye Mullins, Jean Olshefsky, Tony Sanchez, Yvette Sangster, John Shereikis, Sue Smith, Thom Snyder, Jean Toole, Sherry Jenkins Tucker, Cynthia Wainscott, Patrick Waters, Harvinder Makkar

Members Present by Permanent Alternate: Prince Moorman (for Cassandra Price), Colleen Mousinho (for Keith Bostick), Linda McCall (for Brian Dowd), Yosha Dotson (for Jewell Gooding), LaDonna Barnes (for Lucy-Hall Gainer)

Members Absent: Eleanor Brown, Mary Davey, Judy Fitzgerald, Bradley Grover, Ron Koon, Amy Kuhns, Steve Spivey, Faye Taylor, Monica Johnson

Department Staff: Jill Mays, Danté McKay, Dr. Terri Timberlake, Matthew Clay (System of Care Project Director)

Guests: Toyia Mather, Wendy Farmer, Melissa (Mluv) Wallace

Welcome and Introductions

Chair Sandye Mullins called the meeting to order by opening with a moment of silence. The Respect Institute speaker was introduced.

Respect Institute Graduate: Melissa (Mluv) Wallace

Respect Institute speaker, Melissa (Mluv) Wallace, shared her recovery story entitled "Poetry as a Healer". The Respect Institute empowers those in recovery to share their recovery journeys, educating people about mental illness and helping to eliminate stigma.

Review and Approval of Minutes

January Minutes were approved.

Georgia Crisis and Access Line Presentation/ Tour: Wendy Farmer

Wendy shared a brief presentation on Behavioral Health Link prior to taking the council members on a tour of the Georgia Crisis and Access Line (GCAL) call center. GCAL takes on average about 250,000 calls per year. The breakdown of calls that they receive are about 81 % are a primary issue and default issue, 15% are a substance abuse issue and 3% are those who live with a developmental disability, 1.3% of the calls are UTD (unable to determine the primary issue for the call). 75% of their calls are from adults, child and adolescent are about 13% and seniors, over the age of 65, are about 2.76%, unknown are about 9.5%. The calls that GCAL receive are broken down into three categories and they are urgent,

emergent and routine. GCAL recently added texting and chatting as an option for those who may not want to have person to person conversation. The texting and chatting typically takes 45 minutes as opposed to 15 minutes. The app is called "My GCAL" and is available on Itunes and Google. The app has had about 2000 downloads since it began and about 1000 texts and chats. Call center tours were guided by Wendy Farmer and three additional GCAL staff members.

Youth and Families Committee (CYF): Cynthia Wainscott

Cynthia shared information about the committee and the things they had been working on. Cynthia shared that the committee be working on wording they would use in the future to identify their values, things they want to promote and the things that they have championed and the things that will guide them in the future. The list that the Committee has come up with so far is very broad but they are aware that they may not be able to do everything on that list. The committee has committed to having conference calls bi monthly. During the next conference call, the Committee will discuss how they would like to use the extra monies that will be available. The System of Care will primarily use federal dollars. Cynthia mentioned that she is not sure of the exact dollar amount at this time. The committee is devoted to making an impact in the children and families lives that they serve and are making strides in that direction.

DBHDD Children Youth and Families: Danté McKay

Danté shared information about work that has been done in mental health that is relational to children over the last few years. The Governor and Commissioner have received a presentation on "My GCAL" and work related to Autism. The Department of Behavioral Health and Developmental Disabilities (DBHDD) responsibility is to develop and build up crisis services in the continuum of care. Danté introduced Matthew Clay, who is the new full time Project Director for The System of Care expansion grants. Danté shared the information from his report. *For further information see report embedded below:*

BHPAC Office of
Children Young Adu

Chair of Adult Behavioral Health Committee: Jean Olshefsky

Jean shared information from the last meeting of the Adult Behavioral Health Committee. During the meeting Dr. Timberlake went over the Block Grant funding and the different components. The main components discussed were provider training, supportive housing, supported employment, access to services for older adults and criminal justice and mental health. Jean shared that the committee is focusing on coming up with their recommendations before May and that committee will be meeting one more time prior to the May deadline. One of their recommendations will be for expanding funding for mental health courts in various areas. This committee has had robust conversations about identifying and obtaining housing resources and how to retain landlords for the housing for individuals who are in re- entry or coming out of homelessness.

Adult Mental Health: Dr. Terri Timberlake

For further information see report embedded below:

BHPAC Office of
Adult Mental Health

Addictive Diseases: Prince Moorman

Prince shared that one of the providers for addictive disease, is receiving push back from their community. The community is coming at the agency and they are trying to find a way to resolve the issue. *For further information see report embedded below:*

BHPAC Office of
Addictive Diseases 3

Office of Recovery Transformation: Tony Sanchez

Tony shared information about a new initiative called Faith Based and Community Initiative throughout the State of Georgia. That initiative is designed to provide Faith Based organizations with information and skills to support those in recovery. Tony mentioned the upcoming listening sessions that will be held around the state. Tony stated that he has created a recovery policy that came out in January of 2018, which describes the meaning of a recovery oriented system of care. Tony also mentioned that the (CPS) Certified Peer Specialist database has gone live as of March 12, 2019. *For further information see report embedded below:*

BHPAC Office of
Recovery Transforma

Advocacy Committee: Yosha Dotson and Neil Campbell

Yosha discussed a bill for prescription and telemedicine that is currently in the House. She also talked about a School Safe Act that has to do with children. There was much discussion related to House Bill 514, which creates a Georgia Behavioral Health Reform and Innovation Commission.

Office of Federal Grants: Jill Mays

Jill shared that they are on track to talk about priorities and performance measures. These discussions will continue through April. Danté will present a rough proposed plan. Georgia is in the top three and are working with GCAL to make the needed adjustments. *For further information see report embedded below:*

BHPAC Office of
Federal Grant Progr

Nominating and Membership Committee/Orientation Manual: Jean Toole

Jean provided an update on the committees work to update the Orientation Manual. Jean reviewed the manual contents of the manual and asked council members to review and provide feedback. Jean also discussed the committee's thoughts on the orientation process which will involve mentors (current council members) being paired with new council members. The committee is also suggesting that the orientation take place an hour before the new members first council meeting. The committee also thinks it is time to update the council's logo and invited council members to make suggestions.

Recovery Language: Sherry Jenkins Tucker and Neil Campbell

Neil and Sherry discussed recovery oriented language and gave examples of things that could be viewed as offensive or hurtful to others. Neil also mentioned the different trainings that are offered on cultural competency. Sherry encouraged council members to use language that is person centered and identifies the person first as opposed to identifying the person as their challenge.

New Businesses and Announcements

Jill mentioned that Georgia was awarded a technology transfer grant to enhance the crisis bed board capacity. The enhancement will create quicker access to individuals waiting for crisis beds.

Meeting Adjourned

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Chatham Savannah Authority
761 Wheaton St,. Rm 1009C
Savannah, Ga 31401
May 14, 2019
AGENDA

10:00 a.m. **Welcome and Introductions – Pierluigi Mancini, Chair Elect**

- Moment of Silence
- Respect Institute Graduate – Wendy Eugene
- Public Comment

Approval of Minutes for May 2019

9:30 a.m. **Presentation on PATH Program with Carlos Baker**

10:30 a.m. **Tour "Cove at Dundee" Tiny Houses**

12:00 p.m. **Lunch:** Committees Meet

1:00 p.m. **DBHDD and Committee Reports – Areas Of Interest, Challenges and Setting Goals**

- Nominating and Membership Committee – *Jean Toole*
- CYF Committee – *Cynthia Wainscott*
- CYF- *Danté McKay*
- Adult Behavioral Health Committee – *Jean Olshefsky*
- Adult MH- *Terri Timberlake*
- Addictive Diseases – *Prince Moorman*
- Office of Recovery Transformation – *Tony Sanchez*
- Advocacy Committee – *Jewell Gooding*
- Office of Federal Grants and CLC – *Jill Mays*

1:45 p.m. **New Business and Announcements**

2:00 p.m. **Meeting Adjournment**

GBHPAC GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Chatham-Savannah Authority
761 Wheaton St, .Rm 1009C
Savannah, Ga.
Meeting Minutes
May 14, 2019

Members Present: Bertrand Brown, Sharon DeMille, Alan Huth, Amy Kuhns, Pierluigi Mancini, Jean Olshefsky, Tony Sanchez, Yvette Sangster, John Shereikis, Sue Smith, Faye Taylor, Jean Toole, Sherry Jenkins Tucker, Cynthia Wainscott, Patrick Waters

Members Present by Permanent Alternate: Prince Moorman (for Cassandra Price), Yosha Dotson (for Jewell Gooding)

Members Absent: Rebecca Blanton, Keith Bostick, Brian Dowd, Lucy- Hall Gainer, Neil Campbell, Judy Fitzgerald, Ron Koon, Michael Link, Sandye Mullins, Thom Snyder, Steve Spivey, Monica Johnson, Linda McCall,

Department Staff: Jill Mays, Danté McKay, Dr. Terri Timberlake, Kelly Sterling

Guests: Wendy Eugene, Carlos Baker, Ladji Ruffin, Nicole Fields, Ronnie Flournoy, Chris Johnson, Katie Patterson

Welcome and Introductions

Chair Elect Pierluigi Mancini called the meeting to order by opening with a moment of silence. Pierluigi, thanked Mr. Baker and The Chatham-Savannah Authority for the Homeless for hosting the meeting in Savannah. Pierluigi spoke about the loss of Ted Johnson and remembering him during the moment of silence. Following introductions, Pierluigi mentioned the "public comment" section of the agenda and inviting the public to future to give comments, concerns etc. Pierluigi is hopeful that the council will hear more from the community in the future.

Respect Institute Graduate: Wendy Eugene

Respect Institute speaker, Wendy Eugene, shared her recovery story entitled "Blessed". The Respect Institute empowers those in recovery to share their recovery journeys, educating people about mental illness and helping to eliminate stigma.

Review and Approval of Minutes

March minutes were approved.

Chatham- Savannah PATH Presentation/ Tour: Carlos Baker

Mr. Baker gave a presentation on the Region 5 PATH team, which is comprised of five individuals. The Chatham-Savannah PATH team is unique because it is a part of the local continuum of care. The PATH team has several programs which include, permanent housing options, a program called "City 60";

which is a permanent housing unit where individuals can obtain a housing voucher, five emergency shelters for men, two primary emergency shelters for women, to include two other emergency shelters and transitional programs for women and children and a feeding site. The PATH team is comprised of Peer Specialist that have their own lived experience with homelessness and the support of the continuum of care services. The PATH team has been providing services for over 15 years and has had an opportunity to build a rapport with the community over those years. One of the challenges the PATH team faces, is receiving certain crisis services in the community and having affordable and safe permanent housing options in the community. There is a unified referral process, through Department of Behavioral Health and Developmental Disabilities (DBHDD) which is advantageous for those individuals because it provides an extra layer of care. It allows for short term linkages and access to more housing options. The Cove at Dundee is a grass roots program, that has taken four years to get up and going. It is an alternative housing option for veterans. There is currently no one living on the property but that will change this summer. Region 5 PATH team has actively 131 individuals enrolled in the local continuum of care can interact with 231 individuals that are unsheltered. The PATH team interfaces with the four accountability courts which includes drug court, mental health court, family independency court and veteran's court. The PATH team, also interacts with and support individuals from Georgia Regional Hospital. The PATH team goes to meet with an individual at the hospital and enroll them in services, which includes the unified referral services and higher level of care as needed. After the presentation Council Members were led on a tour at "The Cove at Dundee" for homeless individuals who are veterans.

Jean Toole –Nominating and Membership Committee

Jean updated the council on the progress on the New Member Orientation Manual as well as a new logo for the council. The projected date for the finalization of the manual is the next council meeting in July. Jean mentioned the expiration of some council's memberships in September and what categories would need to be filled in that process. Jean noted that a survey will be created to identify other categories that members might possibly be able to fill. Members will be asked to check all areas that apply to them in the survey. Jean also mentioned she will send out information regarding votes for a chair elect nominations.

Youth and Families Committee (CYF): Cynthia Wainscott

Cynthia shared an update on the work that the CYF committee has done between council meetings. This included working on projects to use the extra block grant monies left over. The CYF Committee has worked on values, principles and priorities. Cynthia mentioned that The Department of Behavioral Health and Developmental Disabilities (DBHDD) will make the final decision on how the money should be spent. The other things that are in the Federal Law states that the CYF committee monitor, evaluate and advocate for those services. The reason the CYF is working on principles is to help guide them with consistency. Prevention and early intervention are two of the priorities the CYF committee has set. The planning for the block grant application is on schedule to finalize the spend plans by the end of August.

DBHDD Children Youth and Families: Danté McKay

Danté shared and explained the financial spend report and the Commission on Children's Mental Health. Sue Smith and Danté met to outline the things that need to happen in order to get the ball rolling on the street outreach pilot and having Certified Peer Specialist in the emergency room. The Department of

Family and Children Services has a great interest in the street outreach pilot. The next steps in the program would be to have a meeting with Colleen Moushino, Sue Smith and Danté McKay to formalize the deliverables. Danté shared that there were 13 awards to extend the APEX Program. There were 30 proposals in totality for the funding. The department will hire a fiscal intermediary to support them with the process. *For further information see report embedded below:*

BHPAC Office of Children Young Adu

CYFMH_PROPOSED

MHBG_FY20

Chair of Adult Behavioral Health Committee: Jean Olshefsky

Jean shared about the plan to schedule a meeting with the Children, Youth and Families and Adult Behavioral Health Committees to identify and discuss the Key Performance Indicators. Jean shared her desire to have the recommendations ready by being proactive in making recommendations and working with the department. Jean informed the council that there will be a Doodle Poll sent to CYF Committee members for a meeting soon.

Adult Mental Health: Dr. Terri Timberlake

Dr. Timberlake asked for feedback and suggestions from the council members about the draft DBHDD vision statement. Dr. Timberlake shared that The Department is working on closing gaps in care for those individuals that receive the care. There has been one change that has been made to the proposed block grant spend plan, which is that 40 supported employment slots for Douglas County have been added. *For further information see report embedded below:*

BHPAC Office of Adult Mental Health

Proposed Revised Vision Statement.pd

MHBG_FY20 AMH_PROPOSED SP

Addictive Diseases: Prince Moorman

Prince shared an update on the Opioid treatment epidemic. The grant monies given to addictive disease two years ago has expired. The left over funding has been kept and extended for a third year. The money was used to add additional providers for treatment, which gives more options for individuals to choose from. More information will be shared as data is collected from the grant with outcomes. The data will be collected by the epidemiologist that has been added to their staff. *For further information see report embedded below:*

BHPAC Office of
Addictive Diseases 5

Office of Recovery Transformation: Tony Sanchez

Tony shared about the good work that has been done in the peer workforce. The Georgia Mental Health Consumer Network, along with Appalachian Consulting, in partnership with Department of Behavioral Health and Developmental Disabilities traveled around the state to hold listening sessions. *For further information see report embedded below:*

BHPAC Office of
Recovery Transforma

Advocacy Committee: Yosha Dotson

Yosha discussed Policy Update Governor Kemp signed the Behavioral Health Commission bill (HB514). Appointments are expected within the next few weeks. SB106 (Waiver bill) was also signed and the Governor's office is expected to select one of 6 agencies to make help create the 1115 and 1332 waiver to submit to the federal govt.

Office of Federal Grants: Jill Mays

Jill shared that Atlanta has been selected to host the 2020 ISPS-US (International Society for Psychosocial Approaches to Psychosis) conference. ISPS is a recovery-oriented organization that provides a forum for individuals, families, practitioners, peer support providers, students, and researchers seeking to improve conditions and care for people with mental health challenges. Jill will send additional information as plans develop.

The state Project LAUNCH group has identified a sustainability plan that will be officially announced in late May 2019, more information will be shared after the announcement.

GBHPAC committees are on track with completing tasks for the upcoming MHBG application (i.e. spend plan recommendations and review and development of performance measures). Still to be completed are the Memorandum of Understanding (MOU) between the BHPAC and GMHCN, which will clearly outline the financial agreement. This document would become part of the GMHCN FY20 contract. Since this item has was not completed in time to get a good spending analysis, funding for the BHPAC will have to remain level in the FY 2020/2021 MHBG application.

DBHDD is in the process of applying for SAMHSA's Transforming Lives Through Supported Employment grant. The **S**upported **E**mployme**N**t for **D**iverse **P**opulations (SENDuP) Project will focus on two underserved areas (north central and southwest Georgia) and three underserved populations, i.e. Older Adults (65 and over), Veterans, and American Indians. The project will expand IPS Supported Employment services to an additional 400 individuals (80 annually) over the next 5 years.

For further information see report embedded below:

BHPAC Office of
Federal Grant Progr

New Businesses and Announcements

Jill mentioned that Georgia was awarded a technology transfer grant to enhance the crisis bed board capacity. The enhancement will create quicker access to individuals waiting for crisis beds.

Meeting Adjourned

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**35**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	2	
Others (Advocates who are not State employees or providers)	7	
Persons in recovery from or providing treatment for or advocating for SUD services	3	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**19**	**54.29%**
State Employees	12	
Providers	2	
Vacancies	2	
Total State Employees & Providers	**16**	**45.71%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	9	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**11**	
Youth/adolescent representative (or member from an organization serving young people)	1	

* *States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.*

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Footnotes:
Vacancies:

Two (2) Individuals and Family Members
1. Person In Recovery-Young Adult (Mental Health)
2. Parent of Youth in Recovery (Addictive Disease)

Two (2) State Employees & Providers
1. Provider of Children, Youth and Families Services
2. State Board of Pardons and Paroles

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings? (●) Yes ( ) No

   b) Posting of the plan on the web for public comment? (●) Yes ( ) No

   If yes, provide URL:

   https://dbhdd.georgia.gov/mental-health-block-grant-2020-2021-application-review

   c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

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Footnotes:

Public hearing announcement:

https://classifieds.ajc.com/ads/public-notices/legal-public-hearing/legal-notice-notice-of-public-hearing-in-accordance-500923